



**This electronic thesis or dissertation has been  
downloaded from Explore Bristol Research,  
<http://research-information.bristol.ac.uk>**

*Author:*  
**Zhang, Wenjing**

*Title:*  
**Home Care for Older People in Urban China**  
*An Analysis of the Marketisation Process*

**General rights**

Access to the thesis is subject to the Creative Commons Attribution - NonCommercial-No Derivatives 4.0 International Public License. A copy of this may be found at <https://creativecommons.org/licenses/by-nc-nd/4.0/legalcode>. This license sets out your rights and the restrictions that apply to your access to the thesis so it is important you read this before proceeding.

**Take down policy**

Some pages of this thesis may have been removed for copyright restrictions prior to having it been deposited in Explore Bristol Research. However, if you have discovered material within the thesis that you consider to be unlawful e.g. breaches of copyright (either yours or that of a third party) or any other law, including but not limited to those relating to patent, trademark, confidentiality, data protection, obscenity, defamation, libel, then please contact [collections-metadata@bristol.ac.uk](mailto:collections-metadata@bristol.ac.uk) and include the following information in your message:

- Your contact details
- Bibliographic details for the item, including a URL
- An outline nature of the complaint

Your claim will be investigated and, where appropriate, the item in question will be removed from public view as soon as possible.



**This electronic thesis or dissertation has been  
downloaded from Explore Bristol Research,  
<http://research-information.bristol.ac.uk>**

*Author:*

**Zhang, Wenjing**

*Title:*

**Home Care for Older People in Urban China**

**General rights**

Access to the thesis is subject to the Creative Commons Attribution - NonCommercial-No Derivatives 4.0 International Public License. A copy of this may be found at <https://creativecommons.org/licenses/by-nc-nd/4.0/legalcode>. This license sets out your rights and the restrictions that apply to your access to the thesis so it is important you read this before proceeding.

**Take down policy**

Some pages of this thesis may have been removed for copyright restrictions prior to having it been deposited in Explore Bristol Research. However, if you have discovered material within the thesis that you consider to be unlawful e.g. breaches of copyright (either yours or that of a third party) or any other law, including but not limited to those relating to patent, trademark, confidentiality, data protection, obscenity, defamation, libel, then please contact [collections-metadata@bristol.ac.uk](mailto:collections-metadata@bristol.ac.uk) and include the following information in your message:

- Your contact details
- Bibliographic details for the item, including a URL
- An outline nature of the complaint

Your claim will be investigated and, where appropriate, the item in question will be removed from public view as soon as possible.

# **Home Care for Older People in Urban China: An Analysis of the Marketisation Process**

Wenjing Zhang

A dissertation submitted to the University of Bristol in accordance with the requirements for award of the degree of Doctor of Philosophy in Social Policy in the Faculty of Social Science and Law.

School for Policy Studies

May 2018

Word count: 78,554



## Abstract

The reforms of care for older people have been embarked upon in China as a result of the dramatic demographic and socio-economic changes since the 1980s. Home care is proposed to fulfil the rising care deficit for older people, while the market plays an increasingly active role in the field of care in urban China. This thesis aims to examine how home care policy and practice are shifting in the marketisation context. A qualitative case study approach has been adopted for the empirical research in Shanghai. Semi-structured interviews with home care providers and local government officials compose the main data source, while policy documents, secondary data and literature have been reviewed to support the analysis.

This thesis provides an in-depth exploration of the policy process and policy implementation gap, the shifting dynamics in the mixed economy of care and the re-conceptualisation of ageing and care in the marketisation context. Findings suggest that home care is central to the Chinese care regime and reveal the rationale behind it. Illustrating key strategies of the marketisation of care applied in Shanghai, three models of the “quasi-market” are identified based on the fieldwork data, namely the state-controlled model, the limited competition model, and the free market model. Impacts of the marketisation of care are also investigated in relation to care practice and the entire care regime. This thesis contributes to the understanding of the process of marketisation of care in urban China with empirical evidence and theoretical analysis. Based on the findings and discussions, the conclusion indicates implications for care policy and practice in relation to regulation, geographical inequality and filial obligation in the marketisation context and implications for future research.

## Acknowledgements

I would like to take this opportunity to express my gratitude to those who helped me during the doctoral studies.

Most importantly, my sincere thanks to my supervisors, Misa Izuhara and Liz Lloyd, for their continuous guidance and support throughout my studies. They have helped me develop the ideas and research and kept me on track. Their critical comments and discussions have been invaluable for me to complete this thesis and for my future academic life. I learned a lot from their profound knowledge, wisdom, and attitudes towards research and life. Sincere thanks also go to other academic staff in School for Policy Studies, for advice and encouragement in my studies. Special thanks to Ailsa Cameron and Agnes Bezzina, for commenting on my upgrading report at an earlier stage.

I thank all my interviewees for participating in my study and sharing their rich and informative experiences, thoughts and viewpoints. Special thanks to Honglin Chen and Fei Fang for introducing contacts as I conducted the fieldwork in Shanghai.

Also, my gratitude is given to Paola, Oliver, Mim, Ling, Amelia, Beth, Perada and many others for their friendship. I very much enjoyed getting to know them all in Bristol and spending time with them during these years. Working with my colleagues was a hugely rewarding experience, from which I learned a great deal.

Finally, I want to express my love and thanks to my family who encouraged and supported me over these years. My husband Jason was constantly supportive throughout the ups and downs of my doctoral life and always by my side. Thanks to my parents who kept believing in my ability to achieve the degree and supporting all my decisions. Particularly, I would like to dedicate this thesis to my beloved grandfather, who passed away before I could reach this point but continues to inspire me to grow into my stronger, wiser, happier self.

## Author's Declaration

I declare that the work in this dissertation was carried out in accordance with the requirements of the University's *Regulations and Code of Practice for Research Degree Programmes* and that it has not been submitted for any other academic award. Except where indicated by specific reference in the text, the work is the candidate's own work. Work done in collaboration with, or with the assistance of, others, is indicated as such. Any views expressed in the dissertation are those of the author.

SIGNED: .....

DATE: .....

	Table of Contents	
<b>LIST OF FIGURES .....</b>		<b>VIII</b>
<b>LIST OF TABLES .....</b>		<b>IX</b>
<b>LIST OF ABBREVIATIONS .....</b>		<b>X</b>
<b>CHAPTER 1 INTRODUCTION.....</b>		<b>1</b>
1.1 BACKGROUND OF THIS THESIS .....		1
1.2 RESEARCH OBJECTIVES .....		3
1.3 METHODOLOGY .....		5
1.4 STRUCTURE OF THIS THESIS .....		6
<b>CHAPTER 2 THE MARKETISATION OF CARE FOR OLDER PEOPLE.....</b>		<b>9</b>
INTRODUCTION .....		9
2.1 BACKGROUND OF THE MARKETISATION OF CARE: CARE DIAMOND .....		10
2.1.1 <i>Introduction.....</i>		10
2.1.2 <i>Sectors in the care diamond.....</i>		13
2.1.3 <i>Dynamics in the care diamond.....</i>		16
2.2 THE RATIONALE BEHIND THE MARKETISATION OF CARE .....		21
2.2.1 <i>Definition of the marketisation of care &amp; the path-dependency.....</i>		21
2.2.2 <i>Categories of the marketisation of care .....</i>		23
Types of care regimes.....		24
Types of marketisation of care .....		26
2.3 PROCESSES OF THE MARKETISATION OF CARE .....		27
2.3.1 <i>Contracting out care services.....</i>		28
2.3.2 <i>Financial support for purchasing care services.....</i>		29
2.3.3 <i>Direct purchasing by older people and families in care market .....</i>		32
2.4 IMPACTS OF THE MARKETISATION OF CARE .....		33
2.4.1 <i>Outcomes of the marketisation of care .....</i>		33
Empowerment of service users and equality .....		34
Competition and care quality .....		35
Shifts in the care regime.....		36
2.4.2 <i>The rationale behind diverse outcomes.....</i>		37
2.4.3 <i>Implications for care policy and practice .....</i>		39
CONCLUSION.....		40
<b>CHAPTER 3 THE CONTEXT OF HOME CARE FOR OLDER PEOPLE IN URBAN CHINA .....</b>		<b>42</b>
INTRODUCTION .....		42
3.1 DEMOGRAPHIC CHANGES: POPULATION AGEING, HOUSEHOLD STRUCTURE & OLD-AGE SUPPORT.....		42
3.1.1 <i>The ageing population and rising care needs .....</i>		43
3.1.2 <i>Family planning policy and household changes.....</i>		45
3.1.3 <i>Debates on the “old-age dependency” in urban China.....</i>		49
3.2 MARKET-ORIENTED SOCIO-ECONOMIC CHANGES.....		51
3.2.1 <i>Pathways and the policy process of the marketisation reforms in China .....</i>		52
3.2.2 <i>Reforms of the labour market and job-based welfare system.....</i>		54



3.2.3	<i>Pension system reforms and financial support for older people</i> .....	55
3.2.4	<i>Cultural norms on the family-centred care system</i> .....	57
3.3	REGIONAL DISPARITIES AND RURAL-URBAN MIGRATION.....	59
3.3.1	<i>Differences in socio-economic backgrounds &amp; double-track welfare system</i> ...	59
3.3.2	<i>Rural-urban migration</i> .....	61
3.4	HOME CARE IN THE CHINESE CARE REGIME .....	62
3.4.1	<i>The developmental paths of long-term care policy</i> .....	63
3.4.2	<i>Home care practice in urban China</i> .....	67
	CONCLUSION.....	70
<b>CHAPTER 4 METHODOLOGY .....</b>		<b>71</b>
	INTRODUCTION .....	71
4.1	METHODOLOGICAL APPROACH.....	71
4.2	DATA COLLECTION.....	73
4.2.1	<i>Case study approach</i> .....	73
	Justification of case study.....	73
	Case location .....	75
4.2.2	<i>Semi-structured interviews</i> .....	76
	Justification of the application of interviews.....	76
	Sampling, sample, and recruitment of participants.....	77
4.2.3	<i>Documentary and secondary data</i> .....	82
4.3	DATA ANALYSIS.....	83
4.4	PRACTICAL AND ETHICAL ISSUES.....	85
4.5	LIMITATIONS.....	87
	CONCLUSION.....	88
<b>CHAPTER 5 HOME CARE AT THE CENTRAL POSITION FOR THE MARKETISATION OF CARE IN CHINA 89</b>		
	INTRODUCTION .....	89
5.1	PERSISTENT CULTURAL VALUES OF “FILIAL PIETY” & SOCIAL CHANGES.....	89
5.1.1	<i>Moral and legal obligations of “filial piety”</i> .....	89
5.1.2	<i>Increasing pressure on adult children</i> .....	92
5.1.3	<i>Older people’s attitudes towards saving and consumption</i> .....	94
5.2	HOME CARE AS A MAINSTREAM CHOICE FOR CARE ARRANGEMENTS.....	97
5.2.1	<i>Preferences on home care &amp; lack of shared understanding of terms</i> .....	97
5.2.2	<i>Contested definitions of home care and the structure of care system</i> .....	100
5.2.3	<i>Relationships between care arrangement approaches</i> .....	106
5.2.4	<i>The market as supplement or alternative to families in home care practice</i> ..	109
5.3	COMMUNITY SUPPORT IN HOME CARE .....	111
5.3.1	<i>Volunteer support for older people</i> .....	112
5.3.2	<i>Community quasi-government functional branches</i> .....	113
	CONCLUSION.....	115
<b>CHAPTER 6 EMERGING QUASI-MARKET OF HOME CARE IN URBAN CHINA.....</b>		<b>117</b>

INTRODUCTION: FORMATION OF A QUASI-MARKET.....	117
<b>6.1 PROCESSES OF THE MARKETISATION OF CARE IN URBAN CHINA .....</b>	<b>119</b>
6.1.1 <i>Direct financial support to older people .....</i>	<i>119</i>
6.1.2 <i>Strategies to support the care market .....</i>	<i>121</i>
6.1.3 <i>The diversity of the care market at the local level .....</i>	<i>125</i>
<b>6.2 MARKETISATION MODELS AND THE HIERARCHY OF POWER IN THE CARE MARKET .....</b>	<b>128</b>
6.2.1 <i>The state-controlled model .....</i>	<i>129</i>
Case study example: The state-controlled model in Sub-District Rui.....	130
My fieldwork recruitment process & state-market power relation .....	132
Processes and reasons to adopt the model.....	134
6.2.2 <i>The limited competition model .....</i>	<i>135</i>
Case study example: The limited competition model in Sub-district Zhou .....	136
My fieldwork recruitment process & state-market power relation .....	138
Processes and reasons to adopt the model.....	139
6.2.3 <i>The free market model.....</i>	<i>141</i>
Case study example: large for-profit home care agencies .....	141
My fieldwork recruitment process & state-market power relation .....	144
Processes and reasons to adopt the model.....	145
CONCLUSION.....	147
<b>CHAPTER 7 OUTCOMES OF THE MARKETISATION OF HOME CARE IN URBAN CHINA ...</b>	<b>149</b>
INTRODUCTION .....	149
7.1 UNEQUAL COMPETITION, CARE LABOUR FORCE & FOR-PROFIT MOTIVES .....	149
7.1.1 <i>Increasing but unequal competition in the market.....</i>	<i>149</i>
7.1.2 <i>Care labour force: recruitment, retention and training .....</i>	<i>154</i>
7.1.3 <i>Disputes on the for-profit motivations of care providers.....</i>	<i>160</i>
7.2 CARE QUALITY AND EMPOWERMENT FOR OLDER PEOPLE .....	162
7.2.1 <i>Under-emphasised care quality .....</i>	<i>163</i>
7.2.2 <i>Inequality of choices for older people in the care market .....</i>	<i>165</i>
7.3 DEFICIENT REGULATORY SYSTEM .....	168
7.3.1 <i>Legal framework .....</i>	<i>168</i>
7.3.2 <i>Accountability of the state in the care market .....</i>	<i>171</i>
7.3.3 <i>Regulatory performance .....</i>	<i>174</i>
CONCLUSION.....	177
<b>CHAPTER 8 DISCUSSION .....</b>	<b>179</b>
INTRODUCTION .....	179
8.1 POLICY IMPLEMENTATION GAP OF THE MARKETISATION OF CARE IN URBAN CHINA.....	179
8.1.1 <i>Policy process and power hierarchy.....</i>	<i>180</i>
8.1.2 <i>Inbuilt bureaucratic obstacles at practice level .....</i>	<i>183</i>
8.1.3 <i>Lack of knowledge of practice at decision-making level.....</i>	<i>187</i>
8.2 SHIFTING DYNAMICS OF THE CARE DIAMONDS IN URBAN CHINA.....	191
8.2.1 <i>Care diamonds in the care provision dimension .....</i>	<i>192</i>
8.2.2 <i>Care diamonds in the finance dimension .....</i>	<i>195</i>

8.2.3	<i>Dominant state in the home care market</i> .....	202
8.3	RE-CONCEPTUALISING AGEING AND CARE FOR OLDER PEOPLE IN THE MARKETISATION CONTEXT.....	204
8.3.1	<i>The understandings of “independence” and “old-age dependency”</i> .....	205
8.3.2	<i>Intergenerational support, family involvement in decision making &amp; cohort differences</i> .....	208
8.3.3	<i>Understandings and changing attitudes towards the marketisation of care</i> .....	210
	CONCLUSION .....	216
<b>CHAPTER 9 CONCLUSION .....</b>		<b>218</b>
	INTRODUCTION .....	218
9.1	KEY FINDINGS OF THE THESIS.....	218
9.2	THEORETICAL CONTRIBUTIONS: THE MARKETISATION OF THE INFORMAL CARE SECTOR.....	220
9.3	IMPLICATIONS FOR CARE POLICY AND PRACTICE .....	222
9.3.1	<i>Improving the regulatory system of the care market</i> .....	222
9.3.2	<i>The marketisation in consideration of geographical inequalities</i> .....	224
9.3.3	<i>Filial obligation in the marketisation context</i> .....	225
9.4	STRENGTHS, LIMITATIONS & IMPLICATIONS FOR FUTURE RESEARCH .....	226
<b>REFERENCES .....</b>		<b>229</b>
<b>APPENDIX 1. THE ADMINISTRATIVE DIVISIONS AT PROVINCIAL LEVEL IN CHINA .....</b>		<b>250</b>
<b>APPENDIX 2. STATE STRUCTURE OF SHANGHAI GOVERNMENT.....</b>		<b>251</b>
<b>APPENDIX 3. HIERARCHY IN THE DEPARTMENT OF SERVICES FOR OLDER PEOPLE IN SHANGHAI.....</b>		<b>252</b>
<b>APPENDIX 4. TOPIC GUIDE FOR INTERVIEWS WITH OWNERS AND MANAGERS OF HOME CARE AGENCIES .....</b>		<b>253</b>
<b>APPENDIX 5. TOPIC GUIDE FOR INTERVIEWS WITH LOCAL GOVERNMENT OFFICIALS .....</b>		<b>256</b>
<b>APPENDIX 6. INFORMED CONSENT TO PARTICIPATION .....</b>		<b>259</b>
<b>APPENDIX 7. THE PARTICIPANT INFORMATION SHEET.....</b>		<b>260</b>
<b>APPENDIX 8. CONFIDENTIALITY PROTOCOL.....</b>		<b>262</b>
<b>APPENDIX 9. SCHOOL FOR POLICY STUDIES: RESEARCH ETHICS COMMITTEE APPLICATION FORM.....</b>		<b>263</b>

## List of Figures

Figure 2.1 The mixed economy of care in three dimensions .....	11
Figure 2.2 Social care in three dimensions .....	12
Figure 2.3 Conceptual dimensions of the care diamond .....	13
Figure 2.4 Elder care diamond in China (Ochiai, 2009 p. 69).....	17
Figure 2.5 Elder care in five East Asian societies (Yamashita, Soma and Chan, 2013 p.484)..	18
Figure 2.6 Hypothesised care provision for older people in urban China .....	19
Figure 2.7 Hypothesised finance for older people in urban China .....	20
Figure 3.1 Ageing in China by province in 2020 (percentage of 65 or older group) .....	45
Figure 3.2 Chinese population by age group (1950-2100).....	47
Figure 3.3 Ageing trends under different family planning policies (2010-2050) .....	49
Figure 6.1 Shanghai administrative districts map.....	129
Figure 6.2 The state-controlled model in Sub-district Rui and agency “Happy Home” .....	131
Figure 6.3 The limited competition model in Sub-District Zhou and involved agencies .....	136
Figure 6.4 Coverage of three large for-profit care agencies in Shanghai .....	143
Figure 8.1 Care diamonds in the care provision dimension in the 1990s and 2010s - for longitudinal comparison .....	193
Figure 8.2 Care diamonds in the care provision dimension in the 1990s and 2010s - for dynamic changes in shapes and relationships between each sector .....	194
Figure 8.3 Care diamonds in the finance dimension in the 1990s and 2010s - for longitudinal comparison .....	195
Figure 8.4 Care diamonds in the finance dimension in the 1990s and 2010s - for dynamic changes in shapes and relationships between each sector .....	196

## List of Tables

Table 3.1 The number and percentage of people aged 65 or over in China .....	43
Table 4.1 Sampling criteria.....	78
Table 4.2 Geographical coverage of recruited care agencies .....	80
Table 5.1 Different understandings of home care and the “9073” care system .....	102
Table 6.1 The marketisation strategies and categories of home care providers .....	123
Table 6.2 The pattern of care agency “Happy Home” in Sub-District Rui .....	132
Table 6.3 The different patterns of care agencies in Sub-District Zhou .....	137
Table 6.4 The patterns of three large for-profit care agencies in Shanghai .....	143
Table 6.5 Three models of the quasi-market in Shanghai .....	148
Table 8.1 The interaction matrix of provision and financing dimensions of care for older people .....	201

## List of Abbreviations

CAB	Civil Affairs Bureau
CHARLS	China Health and Retirement Longitudinal Study
EU	European Union
MCA	Ministry of Civil Affairs of the People's Republic of China
NGO	Non-Governmental Organisation
OADR	Old-Age Dependency Ratios
OECD	Organisation for Economic Cooperation and Development
PIS	Participant Information Sheet
POADR	Prospective Old-Age Dependency Ratios
PRC	People's Republic of China
RLE	Remaining Life Expectancy
RMB	Ren Min Bi (Chinese currency Yuan symbolised ¥, 1 Chinese Yuan approximately equals 0.11 British Pound, currency rate in March 2018)
SOADR	Simple Old-Age Dependency Ratio
SOE	State-Owned Enterprise
UK	United Kingdom
US	United States

## Chapter 1 Introduction

---

### *1.1 Background of This Thesis*

Care policy and practice for older people in China have been in need of reform since the 1980s as a result of dramatic demographic changes (Hu and Peng, 2012; Liu, 2012) and socio-economic changes (Jing and Chen, 2009; Shang and Wu, 2011). The population is rapidly ageing in China, where the percentage of older people aged 65 or over has reached 10.8% in 2016 (Ministry of Civil Affairs of China, 2017a). The “one-child policy” has led to a reduction in the number of adult children available to provide care, with the average household size decreasing from 4.43 in 1964 to 3.10 in 2015 (National Bureau of Statistics of China, 2016a).

Meanwhile, the care system is challenged by socio-economic reforms, such as labour market reforms, housing marketisation, and migration (see Chapter 3). For example, increasing female labour participation reduces the number of familial caregivers; the housing marketisation and migration lead adult children to move from their hometowns and purchase estates for nuclear families at another location rather than living with their parents. The socialist care provision for employees of state-owned enterprises (SOEs) in urban areas has been wiped out since the SOEs reforms implemented in the 1990s. These changes challenge the traditional family-centred care system that allocates moral and practical responsibility of caring for older people to family members (usually adult children) and call for investigations on the construction of the care system.

Home care is proposed to fulfil the increasing care deficit in China. The Ministry of Civil Affairs of China (2011a) suggests that home care is the foundation of the Chinese care system, combining community care and residential care. The combination is expressed as “9064” in Beijing (meaning 90% of older people expected to receive home care, 6% community care, and 4% residential care), “9073” in Shanghai, and “9055” in Wuhan (Song, 2014). Yet, the definition of home care has no consensus in policy and practice in China. The terms of “home care” and “community care” are sometimes used interchangeably. The interpretations of care arrangements and their combinations are confusing as well.

Derived from definitions in the Chinese literature and policy documents (see Chapter 3) and interpretations of domiciliary or home care in the European context (e.g. Burau, Theobald, and Blank, 2007; Brennan et al., 2012), I define “home care” as care provided in older people’s own homes by care workers or a mix of care workers and family members, including mixed types of personal care (e.g. nursing), practical care (e.g. cooking, shopping, cleaning) and emotional support. “Community care” implies care services provided in the community, including day-care centres, community canteens for older residents, short-term or emergency care centres, etc. These definitions applied in my thesis are differentiated based on the locations where older people receive services and who the providers are. Drawing on the analysis of documentary and empirical data, Chapter 5 will discuss the definitions of different care arrangement methods and the care system in greater detail.

Care systems are differentiated between rural and urban China due to different demographic trends and the “double-track care system” that allocates social benefits based on the location of household registration (*hukou*) (see Chapter 3). Fewer adult children are available to provide care to older parents due to the tighter “one-child policy” in urban areas (Zhan, 2013), while a large number of the working-age population have migrated from rural areas to urban areas since the 1980s. The caring experiences of rural communities are significantly different from their urban counterparts. Urban residents have more access to financial resources and services from the state and the market than their rural counterparts. With the improvement of the financial conditions of urban families, the employment of care workers becomes more affordable. Besides, local governments are playing a dominant role in care for older people, which might widen “structural imbalances” (Mi, 2014). In this context, the care arrangement in urban China involves more marketised processes. Therefore, my focus is the case of home care in urban China.

Home care is an important research area in a global context with topics that include the governance (Burau, Theobald and Blank, 2007; Brennan et al., 2012), market-oriented reforms (Bode, Gardin and Nyssens, 2011), care arrangements (Williams, 2012; Shutes and Chiatti, 2012), institutional arrangements (Forder, et al., 2004), and stakeholders in care provision (Williams, 2012). Based on a study of home care in Belgium, Germany, Italy, and



England, Bode, Champetier and Chartrand (2013) demonstrate that embedded convergences of the marketisation of care are prominent at the international level, alongside adoptions from other countries and adjustments at the national level. The theoretical discussions and empirical research in Europe and other welfare states (see Chapter 2) are illuminating for the exploration of the marketisation process in urban China.

The market started to play an active role in care for older people in the context of extensive marketisation in urban China in the 1990s. Strategies of the marketisation of care (see Chapter 2) have been implemented in urban China; for example, the state-owned welfare institutions are transforming into social institutions (Zhan, Feng and Luo, 2008). However, there is a gap in the knowledge of the marketisation of home care in China. Existing studies mainly focus on community care in urban areas (Zhou and Walker, 2016; Lin, 2016) or the care deficit in rural China (i.e. “left behind older people”) (Chang, Dong and Macphail, 2011; Yin and Huang, 2011). Even though home care is emphasised in policy documents, the increasingly marketised changes in home care are still neglected areas of research. This thesis therefore addresses a gap in knowledge of the marketisation of home care for older people in urban China.

## *1.2 Research Objectives*

This thesis examines how home care policy and practice are shifting in the marketisation context in urban China. The care system in China is distinctly characterised by its strong state, the traditional emphasis on families, the state-led community, and the increasing market involvement. Therefore, it focuses on how the role of the market is developing; how the other sectors respond to these changes; and how the care regime is shaped by the dynamics and, in turn, shaping care policy and practice in urban China. My primary objective is to explore the process of the marketisation of care in urban China. In doing so, I seek to answer the following questions:

- 1) What is the rationale behind the marketisation of care in urban China?

I examine the pathways of how the care market is growing and the rationale behind the policy process for home care. Cultural values, the direction of care policies and broad influences on

the marketisation process are investigated. I further explore the policy-making and implementation process in relation to the marketisation of home care.

2) How is home care for older people marketised in urban China?

I analyse processes of the marketisation of care that have been applied in urban China. Marketised changes in the home care field are examined, including the increasing involvement of independent care providers, direct purchasing by older people and their families, strategies employed by the state to motivate the care market, state-market relations and the shifting care practice.

3) How is the marketisation process shaping care practice and the care regime?

I explore existing and potential impacts of the marketisation on care practice and the care system. The changes in care provision, finance and regulation of home care in urban China are analysed facilitated by conceptual diagrams of the care regime.

In order to explore these questions, I investigate the views and experiences of stakeholders involved in the home care market and policy priorities and emerging patterns of the care market in urban China. Referring to stakeholders in the care market, Knapp, Hardy and Forder (2001) identified three principal stakeholders in the mixed economy of care in the context of care reforms in the 1990s in England, namely purchasers, providers, and users and carers. In addition to these three stakeholders, regulators (e.g. governments, industry unions) play an influential role in the care market. It is also imperative to differentiate users and carers. In contrast to this highly simplified categorisation, some researchers list many detailed stakeholders involved in home care. For instance, Bolton and Wibberley (2014) investigate domiciliary care in England based on qualitative data collected from carers, managers, social care consultants, staff in care association, trade unionists, service providers and users.

Regarding home care in urban China, I identify five key stakeholder groups in the care market, namely service users, providers, purchasers (including central and local governments as public purchasers and older people and their families as direct purchasers), care workers, and

regulators. Among these key stakeholders, central to my study are the experiences and viewpoints of providers and local government officials (working as public purchasers, policy implementers and regulators in the care market). These two target groups have first-hand information about how home care agencies are organised, how policies are implemented, what kind of marketisation processes are applied, and changes in the regulatory framework. Providers and local government officials are active participants in the care market in urban China, but their views and experiences are absent in existing research. Through a focus on their perspectives, the thesis produces valuable findings of their roles in care policy and practice.

### *1.3 Methodology*

This thesis applies a qualitative approach. It provides an understanding of home care in the context of the marketisation process through the eyes of care providers and local government officials. Specifically, employing the case study approach, semi-structured interviews conducted in Shanghai compose the main data source, while relevant policy documents, secondary data, and academic literature were collected to support the analysis of policy priorities and directions of the development of care for older people.

Considering the geographical case, Shanghai is a metropolis with significantly marketised home care for older people in China. It is one of the most rapidly ageing cities in China, with 2,566,300 people aged 65 or over that accounted for 20.62% of its population in 2016 (Shanghai Municipal Statistics Bureau, 2017). Unsurprisingly, the Shanghai government gives priority to developing social care for older people. Meanwhile, the marketisation level in Shanghai is one of the highest among all provincial divisions in China (Fan, Wang and Zhu, 2011). In this context, strategies of the marketisation of care have been implemented in Shanghai as a pilot scheme for China, such as contracting-out care projects and providing non-cash subsidies (e.g. vouchers, tax concessions) to older people to purchase care services. The increasingly active role of the market in home care makes Shanghai an ideal case for my study, where providers and local government officials are equipped with extensive experience and viewpoints on the marketisation process.

Semi-structured interviews were conducted to explore the views and experiences of care providers and local government officials about the marketisation of home care policy and practice. I employed purposive sampling and snowballing sampling within a recognised range of interviewees. The sampling criteria were informed by positions of owners and managers of home care agencies and working-levels of government officials. Overall, 30 respondents (21 representatives from 13 care agencies, 9 government officials from 5 sub-district jurisdictions) were recruited in my fieldwork. Within the category of care providers, participants include owners or senior managers (e.g. executives, deputies), managers in the care service sector, managers in the marketing sector, and care managers. The group of local government officials includes those who have direct working connections with care providers and service users at the community and the sub-district levels. Thematic analysis, an encoding qualitative information process that involves discovering, interpreting and reporting themes within data (Boyatzis, 1998, Spencer et al., 2014), was applied to process the data collected from semi-structured interviews and policy documents.

#### *1.4 Structure of This Thesis*

Chapter Two will provide a review of the theoretical framework of this study - “marketisation of care”. It will start by introducing the “care diamond” concept that corresponds to the “mixed economy of care” in the field of “social care”. Comparing the convergences and diversities of models of the marketisation of care in different countries, this chapter will then discuss how the marketisation of care becomes a common trend across welfare states. Referring to empirical and theoretical research in the international context, the main strategies of the marketisation of care and the outcomes of these processes will be elaborated.

Chapter Three will explore the context of home care for older people in urban China. It will illustrate multiple influential factors and interactions between them in the field of care for older people in urban China and distinct pathways of the marketisation. This chapter will investigate demographic changes (e.g. population ageing, family planning policy), socio-economic reforms (e.g. labour market, housing, pension system, and cultural norms), and differences of the care systems between urban and rural areas in China. The extensive

marketisation and the significance of home care will suggest the importance to explore the model of marketisation of home care in urban China.

Chapter Four will describe the research design of this thesis and discuss the methodological issues in greater detail. It will justify why the qualitative approach was applied to explore the research questions. The chosen data collection methods will be explained in this chapter, including the case study approach, semi-structured interviews, and documentary and secondary data collection. Importantly, it will illustrate the fieldwork sampling, the recruitment and conducting process of interviews. This chapter will also explain the analytic journey and how thematic analysis is suitable for this thesis and how it was conducted. Furthermore, practical and ethical issues and limitations of this empirical research will be discussed.

Based on the empirical and documentary data, Chapter Five will argue that home care is central to the Chinese social care system, emphasising the persistent cultural norms of “filial piety” and social changes in the family-centred care system, increasing stress on adult children and changing attitudes towards consumption in the care market. This chapter will then elaborate how home care becomes a mainstream choice for care arrangements. It will also compare contested definitions and understandings of care arrangement terms and the structure of the care system and relationships between each approach. The role of the market and the community will especially be examined in supporting families in home care.

Chapter Six will investigate the emerging quasi-market in the field of home care in urban China. This chapter will start with interpretations on how the care market in China echoes the logic of the quasi-market. It will then identify major processes of the marketisation of care applied by the Chinese government. Diverse contracting-out strategies, financial support methods, the power hierarchy in the care market, and state-market relations will be illustrated based on empirical and documentary data. Exemplified by specific cases collected from the fieldwork, this chapter will demonstrate three representative models of the quasi-market in Shanghai: the state-controlled model, the limited competition model, and the free-market model.

Chapter Seven will explore outcomes of the marketisation of home care in urban China. Focusing on impacts on the care system and participants in the care market (e.g. service users, providers, purchasers), this chapter will provide in-depth discussions on prominent thematic topics: disputes on efficiency, competition and for-profit motivations of providers; care quality and the empowerment of service users; and the deficient regulatory system.

Bringing together the findings of this study and existing knowledge, Chapter Eight will draw a bigger picture of the marketisation of care in urban China. This chapter will explore the policy process and the policy implementation gap in relation to the marketisation of care in China. It will then draw the “care diamonds” in urban China, to interpret how different sectors are shifting and the meanings of trade-offs between them. This chapter will critically suggest the reconceptualisation of ageing and care for older people in the marketisation context.

Finally, Chapter Nine is the concluding chapter to summarise the key findings of the thesis. This chapter will also suggest implications for policy, practice and future research.

## Chapter 2 The Marketisation of Care for Older People

---

### *Introduction*

This chapter discusses the theoretical framework of this study - “marketisation of care”- which concerns the application of markets, market principles, and market mechanisms in the field of social care (Daly and Lewis, 2000; Glendinning, 2012; Shutes and Chiatti, 2012; Williams and Brennan, 2012; Bolton and Wibberley, 2014). It includes the background, rationale, processes, and impacts of marketisation of care.

In the first section, the “care diamond” (Razavi, 2007; Ochiai, 2009) concept, a useful tool for elaborating care regime models, is applied to describe the background of the shifting pattern of the marketisation of care. Corresponding to the “mixed economy of care” (Lewis, 1995; Knapp, Hardy and Forder, 2001; Powell, 2007; Glendinning, 2012) in the field of “social care” (Daly and Lewis, 2000; Williams and Brennan, 2012; Lewis and West, 2014), the care diamond concerns four sectors - the state, the market, the family and the community - in the field of care for children and older and disabled adults. Within the care diamond for older people, the market is increasingly becoming an important sector across many countries, including in China, where the pace of socio-economic changes has been rapid in a compressed period (see Chapter 3).

The second section focuses on the rationale behind the marketisation of care. As Williams and Brennan (2012) argued, the marketisation of care is a common trend in many countries (e.g. England, Sweden, Finland, Spain, Italy, Australia, the US, Canada, Japan and Korea) in the context of widespread rising care needs across the world. Meanwhile, the marketisation of care is shaped by demographic, political, cultural, and socio-economic backgrounds and changing pathways. Based on the discussion of the classification of care diamonds, this section explores convergences and diversities among different models of marketisation of care in different countries. Examples in the fields of residential care and home care have been applied for analysis in this chapter since they share common ground on theoretical analysis of the marketisation of care.

The third section illustrates the main processes of the marketisation in the field of care for older people. Combining different arguments, it focuses on three processes of the marketisation of care for older people, namely “contracting out” from the state to independent providers, cash or non-cash financial support to older people and their families for purchasing care services and employing care workers, and direct purchasing in the care market with private funding. The fourth section discusses the impacts of these marketisation processes on the care regime, care market, and participants, as well as explores the factors that might explain different outcomes.

## *2.1 Background of the Marketisation of Care: Care Diamond*

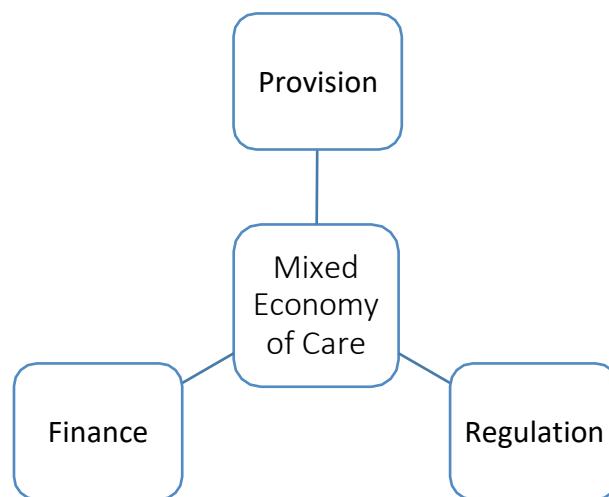
### *2.1.1 Introduction*

The “welfare pluralist” (Evers and Svetlik, 1993) argues that pluralist provision of care is inevitable in a diverse society. The “welfare mix” theory suggests that welfare is provided by the mix of state, market and other sectors (Rose and Shiratori, 1986; Daly and Lewis, 2000; Soma, Yamashita and Chan, 2011). In 1990, Esping-Andersen proposed the “welfare triangle” concept, which argues that welfare regimes are based on the mix provided by three sectors - the state, the market and the family. Gradually, the “third sector” (voluntary and non-profit welfare) or “community” has become involved in the “mixed economy of welfare”, composing the “welfare diamond” (Powell, 2007). The “welfare diamond” concerns four sectors – the state, the market, the voluntary sector, and informal (e.g. family, friends) welfare.

The mixed economy of welfare is evident in the social care field (Hill, 2007). Lewis and West (2014) argue that “social care has always been a mixed economy of provision” in Britain in the post-war period. The idea of mixed economy of welfare has been applied in “long-term care” policy and practice (Soma, Yamashita and Chan, 2011) and home care for older people (Burau, Theobald, and Blank, 2007). Based on the home care practice in Nordic and liberal care regimes (Sweden, England, Australia), Brennan et al. (2012) argue that the mixed economy of care for older people contains four dimensions: state provision concerning social rights through bureaucracies and public organisations; market provision chasing profit through competition; family provision taking moral obligations and emphasising social relations; and for-profit and non-profit associations based on ethical norms and values.



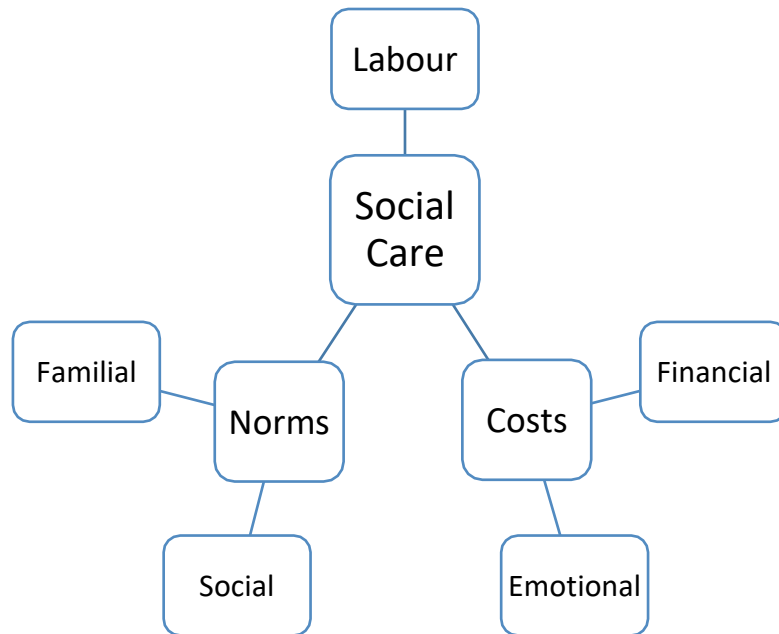
This thesis applies the approach of the care diamond, which visually shows the current development stage of the mixed economy of care. The “care diamond” combines two multi-dimensional concepts: “mixed economy of welfare” and “social care”. The mixed economy of welfare concerns different sectors in the “three-dimensional account”, namely provision, finance and regulation (see Figure 2.1) (Powell, 2007). As Powell (2007) examined, these three dimensions could be practically measured and related to different types of control: provision can be measured by ownership of resources (hierarchical control); finance can be measured by monetary terms (financial control); regulation can be measured by levels of control or power in shaping behaviour (political authority).



*Figure 2.1 The mixed economy of care in three dimensions*

*Source: Powell (2007).*

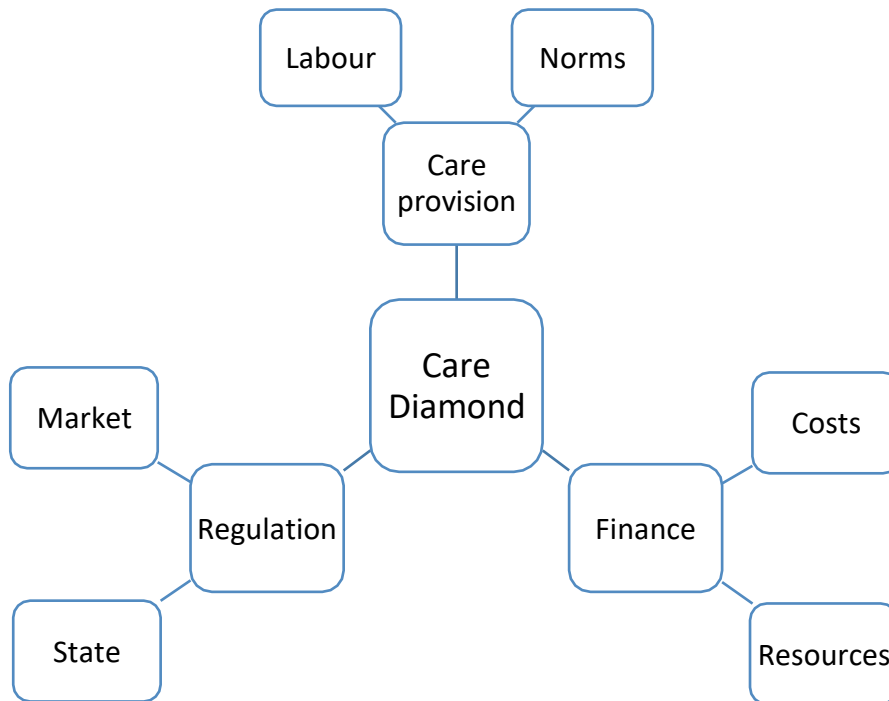
Daly and Lewis (2000) illustrate three dimensions of social care (see Figure 2.2) – care labour, normative framework (social and familial obligations and responsibilities), and costs (financial and emotional support). Both the mixed economy of care and social care include the services and finance of care, while the support to older people is more refined in each dimension in the social care model proposed by Daly and Lewis (2000). Besides, the regulation dimension is not included in the social care model, but it represents an important dimension in the mixed economy of care.



*Figure 2.2 Social care in three dimensions*

*Source: Daly and Lewis (2000).*

Combining these two concepts, this study considers the care diamond in three dimensions (see Figure 2.3): first, care provision in terms of labour and normative framework, containing the delivery, relations, responsibilities and emotional support; second, financial costs and resources; third, regulations by the state and within the market. This thesis explores the changing balance of the care diamond in these three dimensions in order to explore the distinct marketisation process of care for older people in urban China.



*Figure 2.3 Conceptual dimensions of the care diamond*

#### 2.1.2 Sectors in the care diamond

Applying the framework of the care diamond, it is important to analyse the roles of the state, market, family and community in the mixed economy of care. This section discusses the roles of each sector and the relationship between these four sectors in the care diamond.

First, the role of the state varies based on different political, institutional, and socio-economic backgrounds. The state traditionally plays an active role in welfare delivery in welfare states (Powell, 2007); however, recently it has been globally challenged across care regimes. Lund (2007) identifies two challenges in welfare delivery: the new managerialism of welfare delivery has changed from central governments to local and global providers, and the balance between choice and competition based on the public interest is difficult to achieve. In this context, the role of the state is turning from direct welfare service providers to financial support (e.g. cash benefit, tax concession) and regulation (e.g. regulation, inspection, evaluation) (Lund, 2007; Drakeford, 2007). Referring to care provision for older people in England, Lewis and West (2014) argue that the role of local authorities is more on “shaping” and “managing” the market, instead of providing services. Brennan et al. (2012) suggest that the state might enhance transparency and effectiveness of choice in the field of care for older

people by regulating individual providers, including setting up standards of regulations, organising accreditation agencies, and providing information to agencies and care recipients.

Second, the importance of the market is globally growing in the field of care for older people. Drakeford (2007) argues that the market has changed “from the margin to the mainstream” in the agenda of the mixed economy of welfare. Daly and Lewis (2000) and Greener (2008) illustrate that the role of the market is increasingly greater than ever in the “welfare mix” across welfare states. In the field of care for older people, the influence of the market is evident and broadly growing in most welfare states (Brennan et al., 2012), especially in the dimensions of care provision and finance. As Lewis and West (2014) illustrated, the market is dominant in the mixed economy of care in the UK, with the percentage of independent home care services rising from 5% in 1993 to 81% in 2011.

The concept of the market in economics is commonly defined as the abstract mechanisms or process in which exchanges and deals are made between buyers and sellers (Callon, 1998; Pindyck and Rubinfeld, 2013). Yet, the market sector in the mixed economy of care in this thesis implies entities that compete and/or co-operate with one another, as one of pluralist welfare providers together with the state, families and the community. Market mechanisms and principles, such as paid care labour and competitive care market, are discussed as characteristics of the marketisation of care (see Section 2.2). Referring to the care labour, paid care workers in addition to family members are performing an active role for older people who live in either residential care homes or their own homes, especially in high-income economies. For example, foreign care workers are widely participating in care provision in European countries like the UK, Italy, Sweden (Shutes and Chiatti, 2012; Walsh and Shutes, 2013; Lewis and West, 2014) and some East and South-East Asian societies like Singapore and Taiwan (Ochiai, 2009). In the context of extensive marketisation in various fields, the growth of the private sector is increasing in urban China (Feng, et al., 2012). The market started to play an active role in the field of care for older people for care provision in urban China in the late 1990s, which will be illustrated in Chapter 3.

Third, the family is a traditionally influential factor in caring for older people, providing emotional, financial, and direct care support. As Daly and Lewis (2000) proposed, care was

inherently connected with informal support through marriage and kinship, which focused on relations and values of obligation, commitment, trust and loyalty. Finch (1989, p.237) emphasised the importance of family care to Britain, “[c]aring families are the basis of a society that cares”. Yet, the role of family has been changed with the shifting balance of the care diamond throughout the world. Powell (2007) applies the term “informal welfare”, which contains reciprocal and unpaid care from family members, friends and neighbours as one sector in the mixed economy of care. Arksey and Glendinning (2007) argue that the informal sector provides a substantial amount of care to disabled or older people in welfare states, exemplifying the case in the UK where informal care increased from the mid-1990s. In East Asia, the family (separately) is an important sector in the welfare mix (Ochiai, 2009). Based on the historical traditions of “filial piety” and family-centred cultural norms, China particularly values the role of the family. The other provider, neighbours, is commonly discussed in the “community” rather than together with the family in China. Thus, “family” rather than “informal provider” is applied as the third element of the care diamond in this thesis.

In addition, with the theoretical framework developing from “welfare triangle” to “welfare diamond”, the role of the community is increasingly active and recognised in the care diamond. There are arguments about the definition of the fourth sector; these include “voluntary sector” (Lewis, 1993), “voluntary and community sector” (Powell, 2007), “not-for-profit sector” (Razavi, 2007), “not-for-profit and voluntary sector” (Greener, 2008). Analysing care regimes in the East and South-East Asian societies of Korea, China, Taiwan, Thailand, Singapore, and Japan, Ochiai (2009) defines the care diamond with four sectors, namely the state, the market, family and relatives, and the community. Soma, Yamashita and Chan (2011) define the community sector in East Asian societies as provision delivered by informal networks or non-governmental and non-profit organisations. Ochiai (2009) classifies the ranges of the community sector in three aspects: regional networks (e.g. urban neighbourhoods and housing complexes in China); voluntary informal networks (e.g. mothers’ association in Korea and Japan); and officially or deliberately formed function groups (e.g. “*shequ*”: functional organisations established as the fundamental social unit as the forearm of the government in urban China).

Since the second aspect of regional informal networks is not shown significantly in the context of China (Ochiai, 2009), my study considers the community from the other two aspects of Ochiai's definition: not-for-profit and voluntary organisations and neighbourhood networks, and officially formed "*shequ*" as functional groups. The primary function of the *shequ* was to compensate the shrinkage of the socialist system based on the job-related social unit (see Chapter 3). Depending on the institutional and historical background in China, the community is partially dependent on the state. The state usually directs the recruitment and management and allocation of job tasks for community officials. The *shequ* branches play a significant role in mediating the interactions between different sectors. Compared with other East and South-East Asian societies (Japan, Taiwan, Korea, Singapore, Thailand), Ochiai (2009) argues that the community plays the strongest role in care for older people in China.

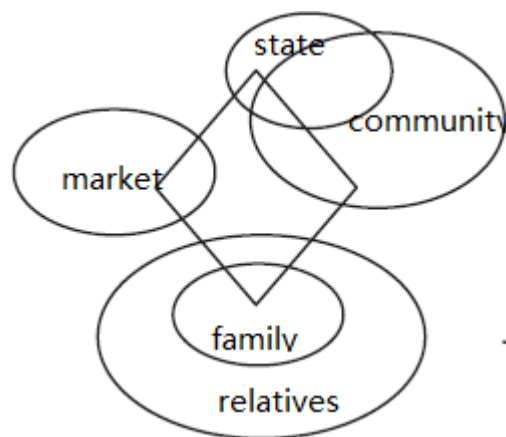
#### 2.1.3 Dynamics in the care diamond

The dynamics of the state, market, family, and community in the "care diamond" contain shifts, trade-offs, and cooperation. When considered across time, the importance of each sector is shifting under changing socio-economic conditions and policy directions. For example, based on studies in Nordic and liberal care regimes, Brennan et al. (2012) suggest that the state has increasingly promoted the role of the market in care for older people in recent decades.

The relationship between these sectors includes two dimensions of cooperation and trade-offs in practice. First, these four sectors are practically collaborative. Powell (2007) argues that the state, the market, the family and the community overlap in the mixed economy of care. For example, cooperation between the state and the market is popular for establishing and operating care institutions. Private care providers may get financial support from the state, which combines different sectors in practice. Second, the trade-offs among different sectors in the care diamond are significant. Drakeford (2007) proposes the interplay between different sectors in three dimensions: shifts between sectors in terms of care provision (e.g. public institutions transferred to private ownership), changes in the dimension of finance (e.g. financial duties moved from the state to the market and the family), and needs for regulating, monitoring, or governing the welfare in the regulation dimension. For instance, Hill (2007)

points out that the state in the UK allocates financial support through “direct payments” for individuals and families to purchase care services in the market.

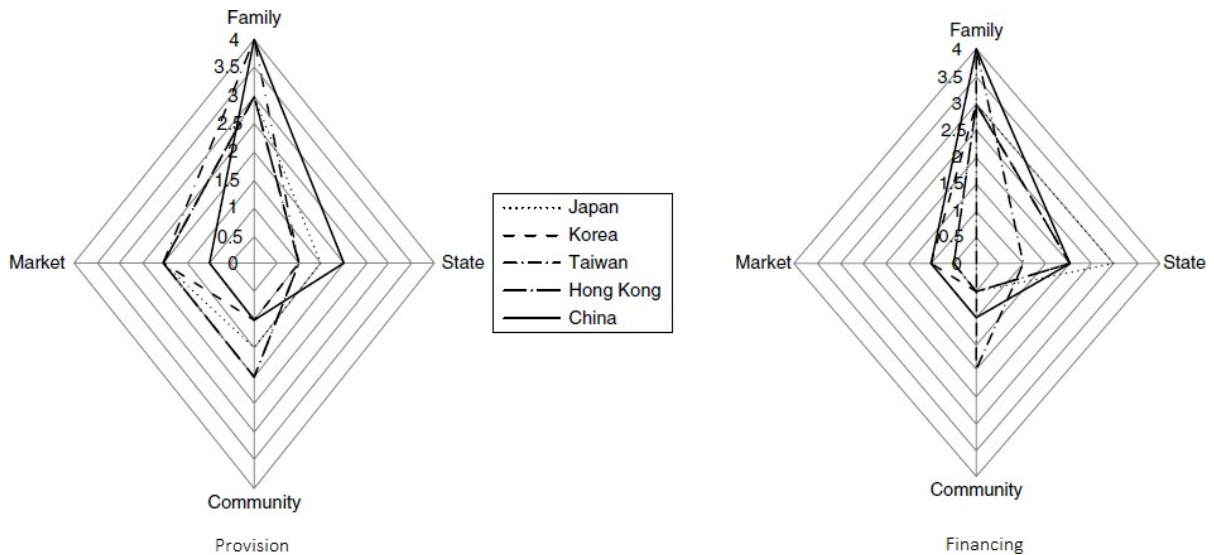
Referring to the case of China, Ochiai (2009) describes the “elder care diamond” in China with the model in Figure 2.4. According to Ochiai’s model, China has a large family sector and a large market sector, which reflects the East and South-East Asian combined familistic and liberalist welfare regimes. She argues that the emphasis of the Chinese socialist regime is moving from the state to the community by applying *shequ* to represent new fundamental social institutions in China. This model proposed by Ochiai (2009) only shows the overlapping function between the state and the community (interactions due to the high state control over the community), while neglecting the trade-offs and cooperation between other sectors. Besides, the differences between dimensions of care provision, finance, and regulation have not been discussed in Ochiai’s model. This thesis develops Ochiai’s model to highlight changes in each sector and especially the inter-sector trade-offs that she neglects.



*Figure 2.4 Elder care diamond in China (Ochiai, 2009 p. 69)*

Yamashita, Soma and Chan (2013) demonstrate care diamonds in five societies in East Asia (Japan, Korea, Taiwan, Hong Kong, and China), where the provision and finance have been separately compared (see Figure 2.5). In Yamashita, Soma and Chan’s model, social expenditure for social care and public/private ratio are applied as indicators in the dimension of financing (the composition of financial resources), while three indicators ( “trends in the use of social care”, “types of service, cash allowance, maternal, paternal, parental and long-

term care leave”, and “trends in the division of social care by family and relative”) are chosen for the dimension of provision.

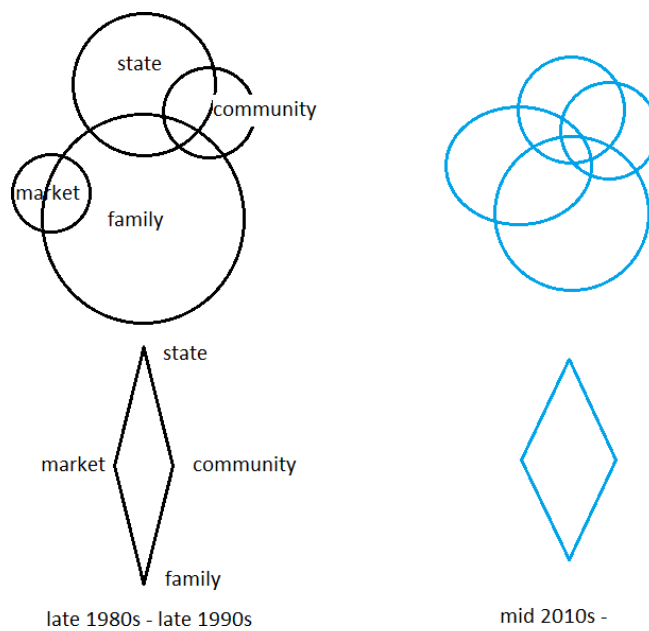


*Figure 2.5 Elder care in five East Asian societies (Yamashita, Soma and Chan, 2013 p.484)*

However, most of the data related to the above indicators (e.g. the number and rate of people using care services) are not available in China. As shown in Figure 2.5, the care diamonds for the dimensions of finance and provision in China proposed by Yamashita, Soma and Chan (2013) are exactly in the same shape, which is not convincing without enough evidence to support them. Meanwhile, compared with Ochiai’s model, diagrams drawn by Yamashita, Soma and Chan (2013) have not considered the connections and trade-offs between different sectors.

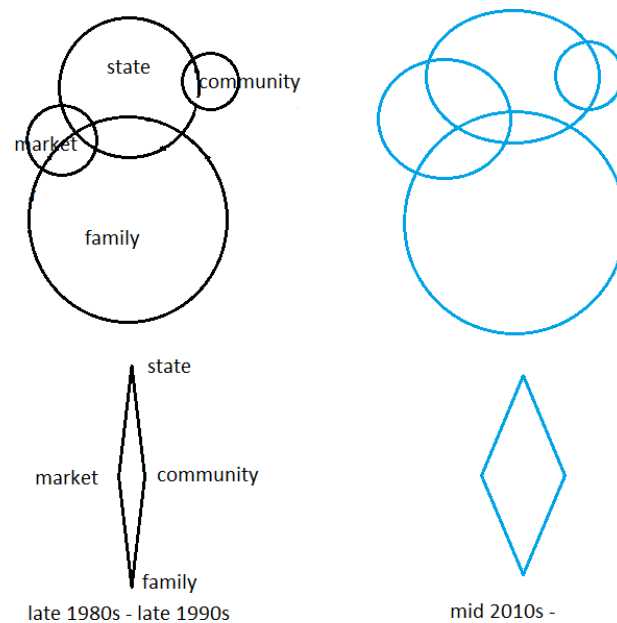
Besides, since the care system varies between urban and rural areas in China (see Chapter 3), it is impossible to represent the care diamond for all of China. To seek greater precision in developing the knowledge of care diamonds in the field of care for older people in urban China, I aim to take account of all four sectors; cooperation and trade-offs between sectors; differences in each dimension of the mixed economy of care; and distinctiveness of the care diamonds in urban areas. Figure 2.6 and 2.7 are two hypothesised conceptual diagrams of the care diamond in urban China in the dimensions of care provision and finance, respectively. The revised diagrams based on the findings of this thesis will be demonstrated in Chapter 8.





*Figure 2.6 Hypothesised care provision for older people in urban China*

Figure 2.6 shows shifts of the care diamond in the dimension of care provision in urban China from the late 1980s when the social welfare sector started the market-oriented reforms. As discussed above, the connections between these four sectors are increasingly significant. The state and the family are decreasing as direct care providers while the market and the community are growing. For example, the market is changing from an informal and uncommon helper of families to cooperate with all other sectors: the state starts supporting agencies in the market through strategies like contracting out services; the combination between the community and the market is increasing (e.g. community agencies involve private providers or private capital); and families increasingly seek help from the care market (e.g. employing care workers).



*Figure 2.7 Hypothesised finance for older people in urban China*

The diagrams in Figure 2.7 show the hypothesised care diamond for the dimension of finance for older people. The financing care diamond embraces monetary and non-monetary financial support to older people in various forms, such as maintenance payments from families, living fees shared by families, public and private pensions, social expenditure through direct or indirect payments, and funding allocation that involves social and community organisations. Contrary to the decreasing care provision, the function of families is turning from direct care providers to financial supporters of older people. The role of the state is also hypothesised to be increasing by expanding the coverage and payment levels of pensions and allocating financial resources to older people and their families (to purchase care in the market). The market sector is expected to play a more active role in the financial dimension (e.g. private pension schemes). The connections between these sectors in the finance dimension might be increased as well, such as the “house-for-pension” program applied in some cities in China in the 2000s.

Overall, the care diamond is a dynamic procedure, which represents the connections and interplay between these four sectors as well as how the balance is affected by changes within each sector and between sectors. Recognition of the multi-dimensional characteristics of the care diamond and interactions between dimensions is imperative for getting a better

understanding of the holistic care system. The model of the care diamond in each country is distinct, based on its demographic, political, cultural, and socio-economic backgrounds. Categories and variations of care regimes are discussed in the next section. Chapter 8 will explore the shifting care regime in urban China with in-depth interpretations and the revised visual diagrams of care diamonds.

## *2.2 The Rationale Behind the Marketisation of Care*

### *2.2.1 Definition of the marketisation of care & the path-dependency*

Marketisation is a worldwide trend across the field of social welfare, including education (Ntshoe, 2004; Lowrie and Hemsley-Brown, 2011), health care (Collyer and White, 2011), voluntary/charity organisations (Mckay, et al., 2015), and care for older people and childcare (Brennan, et al., 2012). As Drakeford (2007) proposed, the marketisation of welfare has various forms, including ownership transforming from the state to independent agencies or individuals, purchasing services from independent providers instead of being directly provided by the state, and relocating responsibilities from the state to individuals. Under the trend of global marketisation, care for older people is increasingly shaped by the growing market.

The term of “marketisation of care for older people” is defined as applying “markets”, “market principles” (Daly and Lewis, 2000) and the “market mechanism” (Brennan et al., 2012; Williams and Brennan, 2012) in the field of care for older people. The “marketisation of care” is a considerably complicated and multi-faceted trend, which involves shifts in the balance of mixed economy of care and increasing faith for applying market principles in the public sector (Daly and Lewis, 2000).

Considering the terminology of the theoretical framework, differentiated theories concern the growing market in the field of social care as well, such as the “commodification of care” and the “privatisation of care”. I apply the “marketisation of care” rather than “commodification” or “privatisation” as the theoretical framework based on considerations of the suitability to the Chinese case. First of all, market mechanisms are being applied in the care field in urban China, which is my primary research objective and will be discussed in

greater detail in this thesis. The term “marketisation” is commonly applied in policy, practice and research across various fields in China since the “Reform and Opening-Up” in the 1980s (see Chapter 3), which leads to the marketisation of care being easier to understand and recognise for different stakeholders. Even though not in a systematic way, the term “marketisation” has been applied in some government policies in terms of care for older people.

Second, similar to the marketisation of care, the “commodification of care” focuses on the on-going shift to entrust care work to the market (Claassen, 2011; Schwiter, 2013); it implies that care is increasingly treated as a commodity to be bought and sold (Leece, 2004). Referring to the primary concerns on “care”, “service” and “process” by different stakeholders (e.g. policymakers, practitioners, and service users) in the care field, the application of market principles (marketisation) is compatible with these emphases of the commodification of care. In contrast, the term “commodity” (*shangpin*) is widely linked to “commercialisation” in the Chinese context, which treats care as a good rather than reflecting its interpersonal nature. For example, “commodification” is a widespread term applied in China’s housing reform (Chiu, 2001; Wu, 2014), which implies the change from the state ownership and distribution to direct purchase with private ownership. What is more, this thesis focuses on the wider process of the application of market mechanisms and following outcomes in the care field, rather than merely that care work has become the commodity. In this context, the commodification of care is less suitable to the discussions on the Chinese marketisation process of care for older people.

Third, the privatisation of care emphasises the involvement of private for-profit organisations and private purchase of care services (Aronson and Neysmith, 1997; Yeandle, Kröger and Cass, 2012). Yet, the term “privatisation” is comparatively at a lower acceptance level for policymakers and the public in the Chinese socialist background, where collective and public factors are prioritised in many fields (at least morally). More importantly, unlike the privatisation path in other sectors such as the health care system (Yip and Hsiao, 2014), care for older people (especially home care) embraces market-oriented reforms but is not on a privatised path in China (see Chapter 6). It is unusual for home care agencies to be certified

or to locate themselves as private providers. The debates on the concept “private” will be discussed in greater detail based on the empirical research and documentary analysis in Chapter 7.

As a “path-dependent” concept, the marketisation of care emphasises relations between each model and its demographic, political, cultural, and socio-economic backgrounds as well as shifts within each model. Williams and Brennan (2012) argue that care policy, provision and practice have the characteristics of “path dependencies”, which are embedded in the context of shifting the balance of the state, market, family, and not-for-profit provision, as well as influenced by ideational movements and cultural practice. For example, based on their studies in Sweden, England, Australia and Canada, models of the marketisation of care vary across countries due to different historical pathways of care provision and institutional contexts.

Cross-national convergences and national path dependency are investigated by Bode, Gardin and Nyssens (2011) based on evidence from France, Belgium, Britain, and Germany. As Daly and Lewis (2000) illustrated, the reforms of marketisation of care on paper are similar, but the actual practice in each country is special due to the context and rationale behind them. For example, Yeandle, Kröger and Cass (2012) propose that the voice of service users is getting stronger in England (with the personalisation process) and Australia (collective voice represented by organisations), while remains limited in Finland based on the de-centralisation background and welfare citizenship system. This chapter concerns existing global experiences to discuss the convergences and diversities of the marketisation of care. The model of marketisation of care in China is distinctly shaped by its developing pathways. Chapter 3 will demonstrate the context of urban China and its distinct pathways.

### 2.2.2 Categories of the marketisation of care

Even though the model of marketisation of care is distinct in each society, it is worth identifying convergences and diversities among them. This section categorises models of marketisation of care in various contexts.

*Types of care regimes*

There is no consensus of the categorisation of care regimes on how social care is organised and arranged. Yet, as Daly and Lewis (2000) argued, the categorisation of care regimes could be useful for the identification of tendencies of care in each country. Existing classifications of care regimes are predominantly based on the context of Europe. For instance, Daly and Lewis (2000) categorised care for older people in European welfare states into three categories: first, the Scandinavian states of extremely collective care; second, central and south European privatisation of care, containing two sub-categories of the Mediterranean model privatised to the family and the central European countries model privatised to the voluntary service providers (e.g. Germany, France); and third, Beveridgean provenance of the collectivised model.

In a simple and basic categorisation, Hill (2007) primarily sorts countries into two categories: countries where family care is predominant (e.g. Italy and Spain), and countries where state care is more salient than elsewhere (e.g. Sweden and Denmark). Focusing on European countries, Brennan et al. (2012) propose three types of care regimes, namely “familial”, “public services”, and “means-tested” patterns. Developed from Esping-Anderson’s (1990) typology for social care regimes, Hill (2007) classifies four categories: 1) Nordic social democratic welfare states, 2) conservative regimes of northern Europe, 3) liberal regimes, and 4) conservative southern European regimes. In addition to the cross-sectional comparisons, the model in each country is in a shifting balance from the longitudinal perspective rather than a static status. For example, Daly and Lewis (2000) categorised care for older people in Britain as more likely to be a collectivised model, although after the past 18 years the level of “marketisation” of care in the UK has been one of the strongest among European countries in the context of shrinking family resources and public services.

In terms of care regimes in East Asia, some researchers allocate it into the existing classification based on the European context. In Hill’s (2007) binary classification, East Asian nations fall predominantly into the family category. Following the same logic, within his four types categorisation, Japan and East Asia are allocated in the category of “conservative southern European regimes”. However, the model of care regime in East Asia and each

country in this area is distinct from European models. Soma, Yamashita and Chan (2011) argue that the unitary definition of “family-centred welfare regime” in East Asia is not accurate, while models are all special in each society, at different periods, and in different provision fields. Ochiai (2009) interprets the pattern of welfare mix in East and South-East Asia as a “familistic welfare regime combined with liberalism”, which has a large family sector and a large market sector. Four sectors of the state, market, family, and community also show significant diversities in the care regimes within East Asian societies.

The care regimes in East Asia are experiencing dramatic demographic and socio-economic changes in a short period. Soma, Yamashita and Chan (2011) argue that the construction of the welfare states in East Asia is compressed and condensed, which leads to intergenerational and generational problems. Families, as the traditionally centred sector in social care in East Asia, encounter new problems during this period. For example, as Ochiai (2009) argued, the traditional responsibilities of adult children are changing from direct care provision to financial support for purchased care in East and South-East Asian societies. These changes in the family sector have led to plenty of risks to the society as well as a push for reforms (Chan, Takahashi and Wang, 2010; Soma, Yamashita and Chan, 2011). Other sectors adjust in response to the changing function of the family sector. Peng (2012) argues that the expansion of social care in South Korea and Japan has been introduced in conjunction with economic and labour market reforms since the 1990s, during which these governments have increased social investment and support for social care.

Based on the “National Surveys on Social Support to Older People in Rural and Urban China” in 2000 and 2006, Shang and Wu (2011) argued that the Chinese care regime remains heavily reliant on families as in the traditional model. However, the survey data applied by Shang and Wu (2011) was collected in 2006 and is outdated due to the dramatic changes since then. Based on China Health and Retirement Longitudinal Study (CHARLS) data (2011), Lu (2014) argues that lots of pilot projects in terms of care for older people have been applied in urban China while rural poor areas remain untouched. The care regime in China is more likely a combination of two models rather than one model shared between rural and urban areas. It

is worth exploring care systems in urban and rural China separately to draw specific pictures of each model.

*Types of marketisation of care*

In responding to the classification of care diamonds, this section aims to clarify the categories of marketisation of care for older people. This thesis draws on the classification of marketisation of care applied by Brennan et al. (2012) and Shutes and Chiatti (2012), focusing on three patterns of “familial”, “public”, and “means-tested” care regimes in Europe.

Mediterranean countries are treated as having a relatively “familial” pattern of care: high levels of unpaid care in families and low levels of institutional care (Bettio and Plantenaga, 2004; Pavolini and Ranci, 2008; Shutes and Chiatti, 2012). The familial pattern is also named as the “southern model” of health care (Bode, Champetier and Chartrand, 2013). The marketisation of care in familial care regimes strongly emphasises family responsibility and home care in both dimensions of care provision and financial support for older people. For example, Shutes and Chiatti (2012) suggest that Italy has legally installed the familial model, requiring families to provide financial support to members who need care.

The care model in Nordic countries has a high volume of “public services” involved (Anttonen and Sipilä, 1996). For example, focusing on public care regimes, Williams and Brennan (2012) propose two types of convergences between the marketisation of care in Sweden and Finland, namely, the market involvement in care provision and the recognition of public responsibility for care. Means, Smith and Morbey (2002) treated England as the “international trendsetter” in the marketisation of care, while Shutes and Chiatti (2012) categorise the UK as a “means-tested” pattern of public care provision. As Drakeford (2007) argued, the privatisation and marketisation of social welfare have grown significantly in the UK since the 1980s. Nevertheless, even though the classification is valuable for analysis, the emphasis of marketisation of care is different in each country.

In terms of the marketisation of care in East Asia, Williams and Brennan (2012) propose that East Asian welfare states (Japan and South Korea) share the common phenomenon of the increasingly popular applications and influences of markets and market mechanisms in the



field of social care. However, as Chon (2015) argued, due to a traditionally prominent role of the family in caring for older people and the underdeveloped long-term care system, research on the marketisation of care is limited in East Asia. With current developments of the marketisation of care in East Asia, it is important to analyse the East Asian model based on its distinct pathways. For example, Ochiai (2009) points out that the role of the state in Japan is strong during the transition of care for older people from pure “familistic regime” to increasingly involving the market sector, with the introduction of its “Long-Term Insurance” policy. Chapter 9 will explore the marketisation process of care for older people in urban China with reference to the processes in other welfare states.

### *2.3 Processes of the Marketisation of Care*

This section discusses different views of the processes and measures of the marketisation of care and illustrates several main processes in greater detail. As a “path-dependent” theory, processes of marketisation of care in different countries have a different emphasis and different practical schemes, which in turn lead to different outcomes (see Section 2.4).

Based on cases in the UK and in Mediterranean countries, Shutes and Chiatti (2012) illustrate three processes of the marketisation of care for older people: contracting-out of care services to private or non-profit providers, applying cash transfers to prompt older people and their families to employ care workers, and private funding of care. Williams and Brennan (2012) demonstrate that the forms of marketisation of care include contracting-out from governments to independent providers (including for-profit and not-for-profit), financial support to promote individuals to enter the care market, long-term care insurance, tax reduction for individuals and families, cash or vouchers for home care, and subsidies or tax reduction to care providers.

Through comparative analysis of market-oriented reforms in England, Belgium, Italy and Germany, Nyssens, Picchi and Simonazzi (2012) propose two routes for activating the marketisation of home care, namely, the direct way from public to market provision (through contracting out services, and promoting policies and regulations in terms of for-profit organisations), and the indirect way from the exclusive purchase by service users and families

to the regular/irregular market with public support (e.g. “cash for care”, tax credits). More specifically, Brennan et al. (2012) and Ding (2013) categorise policies for the marketisation of home care into 1) cash transfer of care insurance schemes or subsidies and cash allowances system to older people for purchasing care services; 2) social insurance for long-term care, 3) tax concessions or housing discounts to encourage the employment of care workers at home; 4) cut back of payment on social security contributions; and 5) other policies to encourage care at home in practice.

Combining these arguments, three main processes of the marketisation of care for older people are identified, namely “contracting out” from the state to independent providers (private or non-profit), financial support from the state to older people and their families to purchase care services or employ care workers, and the direct purchasing by older people and their families in the care market.

#### 2.3.1 Contracting out care services

Contracting out services from the state to independent providers is identified as a major process of the marketisation of care across welfare states. Knapp, Hardy and Forder (2001) argued that the contracting out of services was one of the major changes of social care in the 1990s in England. The contracting out process shows trade-offs between actors in the dimensions of care provision, finance and regulation of the care diamond. Private providers of care for older people are increasing due to contracting out care services from the state provision to both for-profit and non-profit providers (Greener, 2008) and spontaneous participation of private providers into the care provision market. Referring to years of attempts of contracting out services from public provision to the market, Nyssens, Picchi and Simonazzi (2012) demonstrate that the “for profit” sector is larger in Germany and England, while the “not for profit” sector is increasing in Italy. In urban China, Ding (2013) argues that “not for profit” organisations are encouraged to provide home care services through contracting out policies.

The process of contracting out services leads to debates with regard to the impacts on care recipients, care providers and care workers, such as equality, care quality, and regulations. Brennan, et al. (2012) propose the inequality problem after contracting out to independent

providers. As Ungerson (1999) and Shutes and Chiatti (2012) argued, the contracting-out of care services in England led to a dualisation of the care labour market, with one market within the public or non-profit sectors for specialised higher payment care and the other within the private provision for standardised care provided by low-paid care workers. Ding (2013) recognised the urgency to establish standards for home care agencies and for the care quality after contracting out.

China has also seen this process of contracting out care provision in practice. As Jing (2009) suggested, driven by the ideas of “small state” and “indirect state”, contracting out some services to private institutions is a logical choice for the Chinese government. Contracting out of care services has been applied in some pilot schemes in urban China. With the encouragement of the government, the number of independent care providers is dramatically increasing in urban China. Encouraged by the government after the 1990s, “socialised participants” (private, not-for-profit and community agencies) have been increasingly involved in the field of care for older people (Xu and Xia, 2014). The strategy of contracting-out services was initially implemented in Shanghai as a pilot in China in 1998 and becomes representative in the field of care for older people. A number of projects of contracting out care provision have been implemented in urban areas in China since then. Chapter 3 will illustrate the policy context and home care practice in China in greater detail.

### 2.3.2 Financial support for purchasing care services

The process of financial support in this thesis concerns both cash and non-cash schemes funded by the state to encourage older people and families to purchase care services. “Cash for care” policies aim to encourage older people and their families to purchase services in the care market as consumers (Nyssens, Picchi and Simonazzi, 2012). Woolham et al. (2017) demonstrate that “cash for care” is a common strategy applied in Europe and other welfare states, based on the anticipation to increase choice and autonomy, to boost care markets in care provision, to facilitate the shift from residential care to home care, to support family care and to promote cost-effectiveness and efficiency. Based on studies in Austria, England, France, Germany, Italy, the Netherlands, and the US, Ungerson and Yeandle (2007) argue that cash for care schemes seek to empower care recipients together with their carers to make

their own arrangements. As Shutes and Chiatti (2012) revealed, cash allowances are more extensively applied in long-term care in Italy (compared to England) in the field of care for older people. For example, Gori, Chiatti and Di Rosa (2012) propose that 12.5% of older people in Italy were covered by one cash allowance of “*indennità di accompagnamento*” in 2008, which offers the same number of subsidies to all older people regardless of dependency level for purchasing care services and to directly employ care workers.

Non-cash financial support includes various strategies in practice. For example, long-term care insurance schemes (e.g. in Japan, Germany, South Korea) help to pay care service fees for older people who have participated in the schemes (Izuhara, 2003; Bode, Gardin, and Nyssens, 2011). In order to promote the independence of older people and reduce the care stress for their families, the mandatory long-term care insurance has been applied in Japan since 2000, which promotes the involvement of care workers as home helpers (Ochiai, 2009) and emphasises home-based care (Tamiya, et al., 2011).

Financial support policies through social security allowances or contributions are applied by different countries to encourage family members to provide home care services to older people, children, and disabled people. For example, this kind of policy exempts social security payments (for a certain time) when a person is taking care of their family members in the UK and Sweden (Ding, 2013), treating their care work as the fulfilment of social responsibility and deserving of encouragement by the society. Similar strategies have been applied in Germany and Italy on the reduction of social contributions (Nyssens, Picchi and Simonazzi, 2012).

Various non-cash schemes (e.g. tax concessions) are employed to fund personal care (Bode, Gardin and Nyssens, 2011) and to encourage adult children to support older people, which becomes commonly applied in some East Asian societies (e.g. Hong Kong, Singapore) (Ng, 2011). For example, Hong Kong applies “Dependent Parent and Dependent Grandparent Allowance” to co-residents with older people (Hong Kong Government, 1999) as well as tax deductions to adult children or grandchildren who pay fees to care homes for older family members (Hong Kong Government, 2000), while Singapore has introduced the “Proximity Housing Grant” on purchasing houses to people who live with or near their older parents (House and Development Board of Singapore, 2015) to encourage and support families to

care. Brennan et al. (2012) suggest that the tax concessions and housing discounts policy encourage family members to live together with older people as well as enable the employment of care workers at home.

Cash and non-cash schemes and different schemes within each category could either co-exist or separately work in one country. As exemplified above, England has several “cash for care” schemes; Italy provides “cash for care” and non-cash schemes at the same time; while Japan does not apply the cash for care policies. After all, the marketisation of care is a path-dependent concept. Each country makes decisions about which processes to take based on their distinct backgrounds, objectives, priorities and expectations.

Financial support schemes for promoting access to the care market have impacts on care recipients, care providers and care workers. Referring to the impacts on service recipients, both cash and non-cash schemes influence users’ choice and care provision. Cash and non-cash transfers contribute to the maintenance and development of home care for older people. Ungerson and Yeandle (2007) propose that cash for care schemes across welfare states have impacts on care relationships between care recipients, caregivers and care workers, at the same time the private, familial, economic and social life of older people turn from traditional unpaid care to paid care services supported by these schemes. As Nyssens, Picchi and Simonazzi (2012) argued, seeking lower prices of care services, older people and their families either rely on voucher schemes (e.g. Belgium) and reduction of social security contributions (e.g. Germany, Italy) supported by the state, or turn to cheaper services in the irregular care market (e.g. Italy). Considering the impacts on providers, the employment of care workers is influenced by financial support schemes. In Italy, older people and their families increasingly employ care workers at home through cash-for-care subsidies and individual funding (Bettio, Simonazzi and Villa, 2006; Shutes and Chiatti, 2012).

In the context of reduction of family carers and the state provision in China, the government attempts to enable older people and their families to purchase care services from the market by providing financial support. According to policy documents and literature review, both cash and non-cash subsidies have been trialled in urban China. In 2000, the Shanghai government started to conduct home care support schemes for older people in selected

jurisdictions: 12 *jiedaos* (sub-districts as the smallest political divisions in urban China) of six districts. The funding for this scheme was provided by the Shanghai government, with the start-up fund of ¥30,000 RMB (£ 3,300) to each *jiedao* for care facilities and purchasing home care services from independent providers. Since the pilots in Shanghai, many cities have begun trials of home care schemes for older people. Chapter 3 will investigate pilot market-oriented care schemes applied in Shanghai and other urban areas in China in greater detail.

### 2.3.3 Direct purchasing by older people and families in care market

Older people and their families act as direct purchasers in the care market, with or without financial support from the state. As Shutes and Chiatti (2012) argued, the private financial support to older people is significant in “familial” countries (e.g. Italy). Private purchasing offers more choice for older people and their families in the care market while increasing their financial burden. As Glendinning (2012) illustrated with the case in England, “public sector funding constraints” and “extensive marketisation” have promoted both the growing public home care services and the private funding supply. Lewis and West (2014) argue that families are bearing increasing burdens during the marketisation process.

Along with financial support from the state, direct purchasing by service users contributes to the increasing employment of care workers in their own homes. Since the cash-for-care scheme allows older people and their families to look for cheaper services, migrant workers are increasingly providing care to older people in Italy (Shutes and Chiatti, 2012). Migrant care workers have generally expanded the supply in the care labour market. OECD (2011) suggests that increasing migrant workers have been employed in care institutions and older people’s own homes across its member countries between 2008 and 2011.

In this context, some governments make policies to cater to this trend. For example, Nyssens, Picchi and Simonazzi (2012) suggest that families increasingly employ care workers directly for home care in Italy and Germany, either from the irregular market or regular market. Shutes and Chiatti (2012) refer the familial care model in Italy as “migrant in the family”. Regulations in care provision and the care labour market are urgently required in terms of protecting the rights of service recipients and care workers. Referring to the labour force in the field of care in China, the rural-urban migrants increasingly get recruited in care services

in residential institutions and in older people's homes (Ochiai, 2009). Based on a large number of care needs and limited public support in China, private funding from older people and family would be the main way to purchase care services in the market.

#### *2.4 Impacts of the Marketisation of Care*

The marketisation of care for older people has impacts on care recipients and providers and shifts of the care regime. In order to make the best use of the marketisation in the field of care for older people, different aspects of outcomes need to be realised and reasonably addressed. This section explores the complexity of outcomes by elaborating on several arguable themes in Section 2.4.1. Then the rationale behind different outcomes and implications are discussed in 2.4.2 and 2.4.3, respectively.

##### 2.4.1 Outcomes of the marketisation of care

Outcomes of the marketisation of care are examined in different contexts. On one hand, positive outcomes of the marketisation of care have been claimed, including saving expenditure of the state (Bolton and Wibberley, 2014) and service users (Nyssens, Picchi and Simonazzi, 2012), empowering purchasers (Greener, 2008), prompting greater individual choice (Daly and Lewis, 2000; Drakeford, 2007; Williams and Brennan, 2012), giving independence to older people (Shutes and Chiatti, 2012; Bolton and Wibberley, 2014), improving competition and efficiency of providers (Drakeford, 2007; Greener, 2008; Brennan et al., 2012) and enhancing competition of price and quality of care services (Williams and Brennan, 2012).

On the other hand, the marketisation processes in the field of care for older people cannot achieve the ideal model. "Failures" (Forder, Knapp and Wistow, 1996) and "limits" (Lewis and West, 2014) exist in the market and market mechanisms. The limitations of marketisation are commonly discussed in relation to the topics of little consideration of the public interests (Drakeford, 2007), inequalities (Brennan et al., 2012), insufficient competition (Nyssens, Picchi and Simonazzi, 2012), care quality (Glendinning, 2012; Lewis and West, 2014), care relationship (Hardy and Wistow, 1998; Lewis and West, 2014), increasing burden on families (Lewis and West, 2014), ability and information for decision-making and vulnerability of care

recipients (Hardy and Wistow, 1998). The following sub-sections combine the discussions on both the positive and negative outcomes on thematic topics.

*Empowerment of service users and equality*

Based on the theories of neo-classical economics, Greener (2008) proposes two main types of benefits of the promotion of markets in welfare delivery: empowering service users' purchasing power and improving the competition and efficiency of providers. These benefits of marketisation are representative in the field of care for older people. The market provision empowers service users to "exercise consumer sovereignty" (Greener, 2008) through greater opportunities of choice (Daly and Lewis, 2000; Drakeford, 2007). Glendinning (2012) demonstrates that local governments in England emphasise individual choice and the personalisation of service recipients.

While offering greater opportunities to service users to purchase in the care market, the issue of inequality among care recipients has been noticed. Inequalities are embedded in the marketisation of care due to contracting out public provision to the market, insufficient financial support for purchasing services, and different levels of purchasing power among care users. Based on a study in England, Sweden, and Australia, Brennan et al. (2012) argue that there are no remarkable results of lower costs after market mechanisms are applied in the care sector; instead, inequalities among service users have been exacerbated based on their economic background.

The empowerment level is unequal between different groups of service users based on their economic, physical, educational, and family background. Daly and Lewis (2000) argue that the marketisation of social care results in a more systematic and targeted group of service recipients, which would narrow the scope of people who could achieve services. Focusing on the care market in the UK, Lewis and West (2014) point out that there might be significant barriers to care recipients to make choices, especially for those vulnerable groups without enough information or influential status in the care market.

The inequality level of care for older people is dependent on the context of different welfare states. For example, applying data from the "Survey of Health, Ageing and Retirement in



Europe”, Albertini and Pavolini (2017) argue that care regimes based on higher coverage of care provision in Denmark and France enable equal access to formal care and ensure lower inequalities, while those (i.e. Germany and Italy) based on cash-for-care schemes and family funding show higher inequalities in terms of formal care.

*Competition and care quality*

As the other main benefit of the marketisation in welfare delivery proposed by Greener (2008), promoting competition and efficiency is also a common argument in the field of care for older people. Brennan et al. (2012) argue that market mechanisms emphasise the improvement of quality and reduction of costs through competition among providers, which inherently promotes efficiency. Improving competition and quality is an important objective for policymakers to apply market principles in the care field. For example, Chon (2015) suggests that the marketisation of care for older people in Japan and South Korea aims to promote competition and choice.

Competition in the care market and its impacts on price and quality are widely investigated. Nyssens, Picchi and Simonazzi (2012) suggest that competition is insufficient due to the restriction caused by the strong control of the state. The balance between the state intervention and the market freedom is difficult to achieve, which combines different stakeholders and considerations during the policy-making process. Also, objectives of purchasers and evaluation criteria predominantly focus on the results (number) rather than the process (quality). In this context, providers sometimes attempt to compete in unregulated sectors (e.g. reduce the employment cost of care workers), which will not help achieve the primary objective of improving quality and efficiency.

Although the increase in competition is hypothesised to improve care quality and switch the care market from producer-driven to consumer-driven provision, the process and quality of care have not received much attention during the marketisation process. Research outcomes are not as positive as the ideal expectations. Forder and Allan (2014) argue that the increasing competition in reducing prices is highly correlated to the minimum quality in the care home market in England, especially for publicly supported services. As Glendinning (2012) illustrated with the case in England, even though both public home care services and private

funding supply have grown, care quality is potentially harmed in both the public and private home care sectors.

The competition and choice in the market do not necessarily provide a “user-friendly way” (Lewis and West, 2014). For example, some care workers and purchasers only care about the result of whether older people have been fed rather than treated kindly in the process. Lewis and West (2014) critique social care policies over the past thirty years in the UK, which exclusively targeted improving quality via competition among providers and empowering recipients in the market but ignoring the care relationship between care workers and recipients. They criticise the model that care workers undertake personal care on a “task and time” basis in the home care field in the UK, which easily leads to a rushed working pattern of care workers in a very limited time. The time-focused working and competition pattern cannot guarantee the quality and interpersonal relationship and even might deteriorate the service quality.

#### *Shifts in the care regime*

The marketisation of care not only has impacts on the market sector but also on the other sectors and the care regime. In addition to the market, other sectors have been involved in the marketisation of care as well as been influenced by the process. For instance, state expenditure was saved in England after contracting out services (Lewis and West, 2014). Based on their research in Germany, England, Belgium, and Italy, Nyssens, Picchi and Simonazzi (2012) argue that the marketisation of home care influences the state, families, for-profit organisations, the third sector, and care workers.

Families provide substantial financial support and informal care, especially to those older people who cannot afford care services in the market themselves or even after being granted public support. Daly and Lewis (2000) suggested that the marketisation might give more choices for older people and their families while pushing “compulsory altruism” (Land and Rose, 1985) on family carers. Similarly, Lewis and West (2014) suggest that the marketisation enhances the burden of the family by promoting increased informal care. In this case, it is informal care workers who must pick up the slack. However, the encouragement to informal care has boundaries and limitations. Powell (2007) illustrates the “do-it-yourself” policy:

where individuals and families construct their welfare model by combining different sectors themselves.

Moreover, the support level among different local governments is diverse. Arksey and Glendinning (2007) argue that some authorities in Britain managed to improve support to informal carers, but the support is not consistent across areas. Based on multi-level public support from local governments and the economic background in each jurisdiction, geographical disparities are also representative in China, which will be discussed in Chapter 9.

#### 2.4.2 The rationale behind diverse outcomes

The arguments on the impacts of the marketisation of care represent a gap between ideal assumptions and unexpected reality. Some negative outcomes are related to the characteristics of the marketisation of care; for instance, the extended market taking over public provision (contracting out) would lead to less attention to public interest and equality. Yet, some negative outcomes are opposite to the claimed positive assumptions. Nyssens, Picchi and Simonazzi (2012) argue that the marketisation of care would save money for older people and their families. However, Lewis and West (2014) argue that contracting out care services does save money for the state, while the burden of families is not certainly reduced.

Those potential benefits of the ideal market have certain conditions: sufficient information to both buyers and sellers; due influence on price per unit; and no sunk costs for entering and exiting the market (Greener, 2008). However, in the field of social care, it is difficult to reach these conditions (Land and Himmelweit, 2010). Brennan et al. (2012) suggest that an ideal care market should be a competitive one with freely available information about price and quality of services as well as low costs for changing service providers. In practice, first, consumers cannot equally assess the price and quality of services, because of quality differences and unequal assessment skills (Eika, 2009). Second, changing carers or service providers cannot be easily achieved due to considerations of monetary costs, care quality, as well as psychological costs (Bode, Gardin and Nyssens, 2011). Besides, the competitive market cannot be fully assured as there are various suppliers and government intervention (Brennan et al., 2012).

“Market failures” are embedded in long-term care markets across welfare states (Fernández, et al., 2009). At an earlier stage of the mixed economy of care in the 1990s in the UK, Forder, Knapp and Wistow (1996) illustrated “structural” and “information” market failures in social care markets. Regarding structural failures, in the short term, both insufficiency and over-supply exist in different aspects of the supply in the care market; in the long term, there are barriers to entering and exiting the care market, including exogenous cost advantages, labour and capital supply constraints, underdeveloped suppliers and non-recoverable costs, the vulnerability of service users and product differentiation. Three information imperfections in the care market were identified: “moral hazard of hidden information” that care purchasers are reliant on the providers to get information; “moral hazard of hidden actions” of providers that misrepresent the quality of care services to the purchasers; and “adverse selection” that providers get the power to select service users (e.g. only accepting low-dependency older people as care recipients).

The inherent market failures reveal the difficulty to make judgements in the care market. Social care services are “experience goods” (Forder, Knapp and Wistow, 1996; Stiglitz and Rosengard, 2015) that can only be measured after purchase or use. Purchasers in the care market (the state and older people and families) sometimes have poor information and knowledge of the care market when making decisions. As Lewis and West (2014) argued, individuals who are in need of care services might not have access and information to the social care market. Older people as service users cannot always arrange their own care schedule.

Based on the analysis of the marketisation of home care in four Western European countries, Bode, Gardin and Nyssens (2011) argue that stakeholders in the care markets in the UK, Germany, Belgium, and France do not have equal access to informational opportunities, where providers always take advantage of service users, purchasers, or public commissioners. Meanwhile, based on objective restrictions (e.g. ability, timing, resources), the decisions made by the state cannot be optimal either. Leichsenring, Winkelmann and Rodriogues (2014) argue that government failures have shaped the processes of quasi-markets to produce

different outcomes in sampled European countries (England, Denmark, the Netherlands, and Germany).

Besides, based on the path-dependency of the marketisation of care, outcomes are different and sometimes even opposite in different contexts. For example, acknowledging the common trends in the trajectories of quasi-markets, Leichsenring, Winkelmann and Rodriogues (2014) illustrate different outcomes of the application of markets in several European countries, showing that for-profit providers of residential care and home care are increasingly influential in Germany and England, while home care markets are at a relatively small scale in the Netherlands and Denmark.

Thus, the social care resources cannot be allocated efficiently and effectively due to various imperfections. Yet, the inefficiency of market allocation is exaggerated sometimes. As Forder, Knapp and Wistow (1996) argued, even if markets fail to act in an ideal way, developments of the market have improved efficiency. The expansion of the care market and increasing diversity have responded to the increase in care demands (Netten, et al., 2005).

#### 2.4.3 Implications for care policy and practice

The marketisation of care has mixed outcomes and variations in different contexts. It is important for the state and individuals to gain a better understanding of the care market. Before applying the marketisation strategies, it is worth evaluating the existing evidence, identifying distinct pathways of the specific context, taking pilot schemes, and setting up regulations at an earlier point in response to market failures. Meanwhile, service users could benefit by recognising “information failures” in the care market when they make decisions.

During the application of the marketisation schemes, regulations are necessary for managing unexpected negative outcomes. Pavolini and Vanci (2008) argue that new regulatory frameworks have been set-up in response to the marketisation of care across welfare states, so as to reduce the risks of market failures and guarantee competition and empowerment of choice. Forder, Knapp and Wistow (1996) proposed two methods for local governments to deal with market failures, namely direct intervention by the state and leaving it to the market. Different methods have been applied by welfare states to regulate the care market. As

Pavolini and Vanci (2008) exemplified, Germany set up rigid prices and standards of care services; the UK government developed commissioning methods to allocate funds to agencies; and France and the Netherlands designed assistance plans with the involvement of benefit recipients to determine the content of care services.

The regulatory system of care for older people needs further development. Glendinning (2012) and Lewis and West (2014) illustrate the fragmentation and gap of regulation existing in the field of home care in England. Evaluations of schemes during the implementation process are important for the regulation of the care market. It is also important to balance the tension between more regulations of the market and counterproductive burdens being placed on providers, which is actively a debate in some welfare states, such as England.

### *Conclusion*

Viewing the macro picture of the marketisation of care for older people, it is beneficial to seek a better understanding of changes in the care regime and different sectors and their relationships. The shape of the care model constantly shifts as well as varies between countries based on different pathways. In the shifting dynamics of the care diamond, the core issues raised by the marketisation of care are processes relating to how the market mechanisms are applied and following outcomes.

After discussing different views on the processes of the marketisation of care, this chapter focused on three categories: contracting out from the state to independent providers, financial support to older people and families to purchase care services in terms of cash or non-cash schemes, and direct purchasing by service users through private funding. These processes lead to diverse outcomes, which are debated among researchers and dependent on application backgrounds. Based on literature in the international context (predominantly in Europe), this chapter discussed the impacts of the marketisation of care for older people on care recipients and providers and shifts of the care diamond, under the thematic topics of the empowerment of service users and equality, competition and efficiency, quality and care relationships, and shifts of care regime. Arguments and empirical examples of both positive and negative aspects have been illustrated within each topic. In addition, market failures and

state restrictions have been discussed to explore the rationale behind different outcomes, before suggesting implications for regulation by the state and within the market.

These identified processes of the marketisation of care for older people have been taken into pilot schemes in urban China; however, there is no systematic study conducted within the framework of the marketisation of care yet. As a path-dependent term, the marketisation of care in urban China is a distinct case. The Chinese situation is different in a number of significant respects. The models in familial countries in Europe (e.g. Italy) and cases in East Asia countries (e.g. Japan, South Korea) provide references to China as extensively applying marketisation strategies. Based on the theoretical framework of the marketisation of care, this thesis explores the case of care for older people in urban China, where home care is investigated as the main care arrangement approach in the marketisation context.

## Chapter 3 The Context of Home Care for Older People in Urban China

---

### *Introduction*

Before exploring the process of marketisation of care, this chapter illustrates the changing context of home care for older people in urban China. Policies, practice and other factors (e.g. political ideologies, economic background, social values, employment) have simultaneous influences and counter-influences at work (Hill, 1997; Lloyd, 2012). This chapter illustrates influential factors (e.g. demographic changes, socio-economic reforms, and the changing role of families) and interactions between these factors in the field of care for older people in urban China.

Long-term care policy and practice for older people in China have been in need of reform since the 1980s. In this chapter, Section 3.1 discusses demographic changes in urban China in dimensions of population ageing and family planning policy. Section 3.2 illustrates socio-economic changes in cultural norms, the labour market, housing market, and the pension system. The dramatic speed of ageing and unprecedented scale of population ageing raise a significant amount of care needs. Families, the traditional care providers, cannot bear the duty of increasing care provision anymore. It is an urgent task for China to figure out how to cover the care needs of older people. The chapter then moves on to discuss disparities between urban and rural care systems in Section 3.3. Section 3.4 examines the importance of home care, the shifting roles of the state, market, family and community in the field of care for older people, and the marketisation trend of home care in urban China.

### *3.1 Demographic Changes: Population Ageing, Household Structure & Old-Age Support*

China's ageing issues are distinctive in the context of "getting old before getting rich" (*weifu xianlao*). As Hu and Peng (2012) argued, China turned into an ageing society in the context of the developing economy, insufficient employment level, and underdeveloped social welfare system. Unlike welfare states, China is facing the ageing embedded in its huge population and at a time when the economy and the welfare system are not developed yet. The process of population ageing and shrinkage of the younger population challenge the traditional care



system that relied on family support in China. Meanwhile, the implementation of family planning policies has exaggerated the process. Adult children have struggled in caring for older people in the context of the changing family structure in recent decades.

### 3.1.1 The ageing population and rising care needs

The population is rapidly ageing in China, where the percentage of people aged 65 or over had reached 10.8% by 2016 (Ministry of Civil Affairs of China, 2017a). Care needs keep increasing in recent decades. In the context of the extension of life expectancy and the decrease of fertility rate, the number of older people and the proportion of older people in the population have been dramatically rising in China since the 1980s. Based on the China Census (National Bureau of Statistics of China, 2010) data, China turned into an ageing society in 2000 with the percentage of 65 year olds or over representing nearly 7% of the whole population (The United Nations definition: the population aged 65 or over reaching 7% is an ageing society). The number of older people in China approached 144 million in 2016, which has increased by 63.29% since 2000 and 127.82% since in 1990 (see Table 3.1).

*Table 3.1 The number and percentage of people aged 65 or over in China*

	1953	1964	1982	1990	2000	2010	2016
Percentage (%)	4.41	3.56	4.91	5.57	6.96	8.87	10.5
Number (1000)	26,211	24,727	49,502	63,146	88,102	118,832	143,860

*Source: 2010 China Census (National Bureau of Statistics of China, 2010); National Bureau of Statistics of China, 2017a.*

In addition to the substantial older population, the composition of older people (e.g. age groups, the disability rate) shows rising care needs in China. Based on the 2010 China Census data, Chen and Jordan (2018) predict that the oldest old group (aged 80 or over) would account for 12.5% (30,670,000) of the total older population by 2020. Multiple datasets examine the disability rate in China (commonly assessed by the “Activities of Daily Living Scale”, which evaluates routine activities like eating, dressing, bathing, toileting, walking),

including the “Sample Survey on Aged Population in Urban/Rural China” in 2000, 2006 and 2010, “Chinese Longitudinal Healthy Longevity Survey” from 1998 to 2011, “China Health and Retirement Longitudinal Study” in 2011, “National Sample Survey on Disabled People” in 2006, “Health and Service Survey” in 2008, and China Census in 2010. Comparing data presented by these data sources, Zhang and Wei (2015) argue that the disability rate of Chinese older people is between 10.48% and 13.31%, which is highly influenced by age, gender, and geographic differences (i.e. rural or urban residents).

According to the national surveys data, the number of older people with disabilities or dementia was over 40 million in China in 2010. In this context, the Ministry of Civil Affairs of China (2011b) planned to increase the number of care workers for older adults (including residential care, home care and community care) from 30 thousand in 2010 to 6 million in 2020. The China Philanthropy Research Institute at Beijing Normal University (2017) argues that this target number is impossible to reach by 2020, because the number of care workers is less than 500 thousand in 2017, among which only 20 thousand are qualified care workers with professional qualifications.

At the same time, the process of ageing is different in each geographical area. The percentage of the ageing population in the eastern area (more developed) is generally higher than the ageing level in poorer western provinces (with predominately rural areas). Based on the census data in 2010 (e.g. the population structure, the migration input and output, and fertility rates), the Economist Intelligent Unit (2014) estimates the ageing level in each different area in China (see Figure 3.1). They argue that the north-eastern area will be the earliest ageing provinces based on large outbound migration to other areas and low fertility rates.

Figure 3.1, Ageing in China by province in 2020 (percentage of 65 or older group), has been removed for copyright reasons.

*Figure 3.1 Ageing in China by province in 2020 (percentage of 65 or older group)*

*Source: The Economist Intelligent Unit, 2014 p. 14*

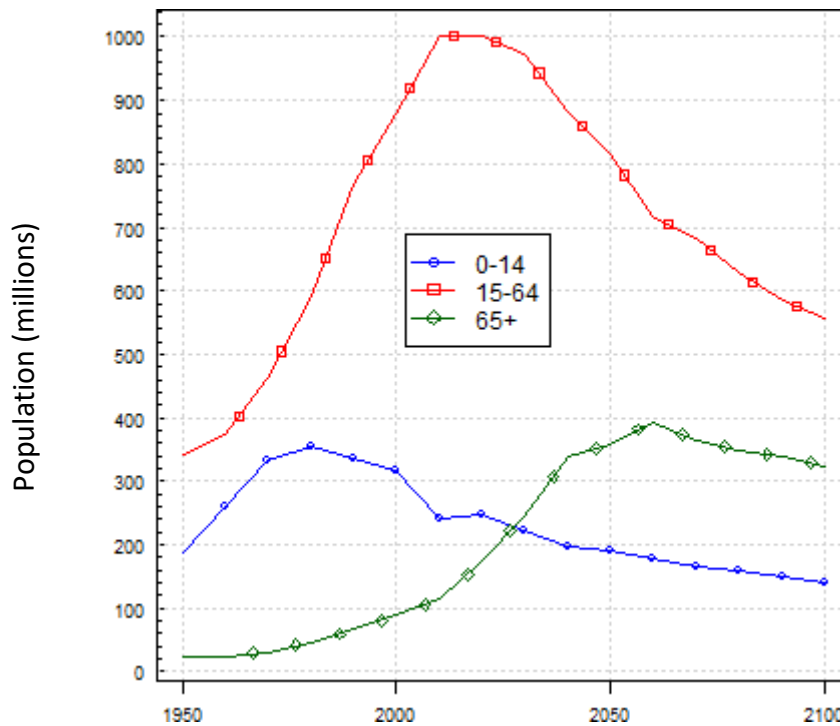
### 3.1.2 Family planning policy and household changes

The family planning policy started in the 1950s, during which the government encouraged the public to hold temperate attitudes towards giving birth to children (policy encouragement without compulsory actions). In 1979, the family planning policy turned to administrative control, under which births were controlled by strict state quotas. The central government and local governments of each province implemented trials of family planning policies, imposing severe punishment to “illegal” births (one legal child only for each couple, except for minority groups). In 1983, the National Family Planning Committee raised the policy to put a compulsory intra-uterine device to women after their first child born and to operate compulsory sterilisation if they got a second child. After 1984, there were some adjustments to the one-child policy in some provinces. For example, rural residents may have a second child if their firstborn was a girl; couples who are both one-child themselves could have a

second child. However, these less strict policies did not get a chance to be implemented in most provinces until the early 1990s.

The fertility rate in urban China has dramatically reduced since the imposition of the “one-child policy” in 1979 (see Figure 3.2). The fertility rate in China has been lower than the replacement rate to maintain the total population (i.e. the average of 2.1 children per couple) since 1992. The “one-child policy” in the 1980s led to a gradual reduction of younger generations of the population pyramid (Li and Peng, 2000). As Figure 3.2 shows, the 0 to 14 age group has a decrease after the 1980s, while the ageing group (65+) keeps a rapid increase. According to the China Census (2010) data, the Chinese fertility rate was 1.22 in 2000, one of the lowest among all countries.

Even though the fertility rate was so low in China, the family planning policy did not change in the 1990s. Central Committee of the Communist Party of China and the State Council put forward two determinations in 2000 and 2007, *“Reinforce Population and Family Planning to Maintain the Low Fertility Rate”* and *“Strengthen the Population and Family Planning and Address the Population Problem in an Integrated Manner”*, respectively. The fertility in China decreased to 1.18 in 2010 (National Bureau of Statistics of China, 2010). In the context of the rapid ageing and the decrease of working-age population, the dependency rate in China dramatically increases.



*Figure 3.2 Chinese population by age group (1950-2100)*

*Source: United Nations, Department of Economic and Social Affairs, Population Division (2017). Retrieved from <https://esa.un.org/unpd/wpp/Graphs/DemographicProfiles>*

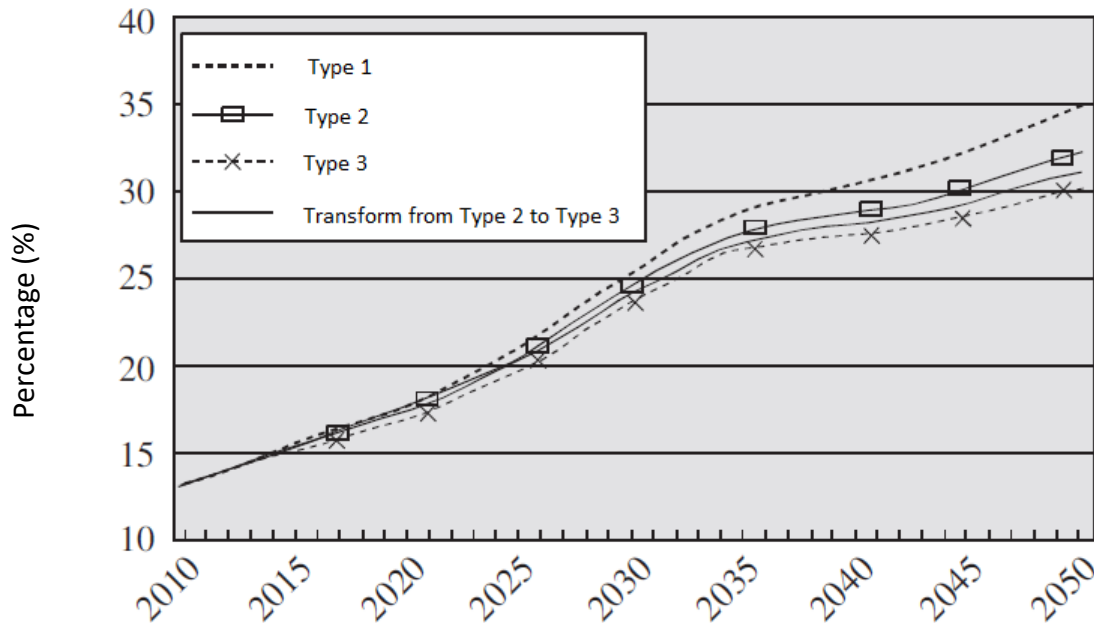
In the context of demographic changes, the household size in China is becoming smaller with a higher mobility than ever before, regardless of rural or urban areas (Du and Tu, 2000). The average household size decreased from 4.43 in 1964 to 3.10 in 2015 (National Bureau of Statistics of China, 2016a). Considering traditional familial caregivers, the number of adult children who are available to provide care to their older parents is decreasing. As Zhan (2013) argued, the generation who were born during the baby booming period (i.e. the 1960s) generally will have only one child in urban areas or fewer children in rural areas. In this context, it is difficult for adult children to carry out the responsibility of traditional family-centred care provision. The old family-based care system needs to be modified.

The family planning policy has been less strict in China since the late 2000s. By 2007, most provinces in China had deregulated the strict one-child policy, allowing couples to have two children if parents are both single-child. Later in 2013, the central government determined to allow couples to have a second child if one of the parents is a single child (Central Committee

of the Communist Party of China, 2013). The application for a second child under this policy was just over 1 million in 2014, which was much lower than the state expected (more than 2 million). Later, the “Law of the People's Republic of China on Population and Family Planning” was revised to allow and encourage all couples to have two children from January 2016, which ends the one-child policy.

However, policymakers are surprised again by the outcomes of the implementation of the “two-kids policy”. According to the data released by the National Bureau of Statistics of China (2018), the number of births and the fertility rate in China both decreased in 2017 (i.e. 17,860,000 births in 2016, 17,230,000 in 2017; the birth rate reduced from 1.295 to 1.243 per cent). What is more, according to the National Health and Family Planning Commission (2018), over 51% of the new-borns in 2017 are second children in their families (especially for middle-aged women who are close to the end of their fertility age), which shows the low childbirth willingness of younger generations. The changes in attitudes and behaviours in childbirth have gained attention from policymakers and researchers.

As many researchers estimated, the developmental family policy and changes in birth-rates would reshape the responsibility and function of families in care provision for older people. Hu and Peng (2012) evaluated percentages of older people among the whole population in China from 2010 to 2050, under four types of “family planning policy”: type 1, only if parents are both one-child, they are permitted to have a second child; type 2, when at least one of the parents is one-child, they are permitted to have a second child (applied from 2011); type 3, any couple can have a second child (applied from 2016); type 4, the transform stage from type 2 to type 3. In recent years, the family planning policy in China has become less strict, but the population ageing keeps significantly increasing. As Hu and Peng (2012) predicted, the percentage of older people in 2030 will be double the number in 2011: older people aged 60 or over (retirement age in China) would represent 35% of the whole population and the group of older people aged 65 or over would reach 26% of the whole population.



*Figure 3.3 Ageing trends under different family planning policies (2010-2050)*

*Source: labels modified and translated from “percentage of older people (aged 60 or older) among the population” (Hu and Peng, 2012 p.67)*

The increasing older population and decreasing births inevitably show risks to care provision for older people in China. Yet, filial support continues to play an active role in the process of social changes in China (see Section 3.2.3). Adult children still provide practical and personal support to their parents (Zhan et al., 2006; Feng et al., 2012). With empirical data collected from Shanghai, Chapter 5 will explore the role of families and cultural norms in care for older people and the rationale behind it.

### 3.1.3 Debates on the “old-age dependency” in urban China

“Old-age dependency ratio” is the most widely applied measurement to demonstrate the ageing degree of a society (Holzmann, Macarthur and Sin, 2000; Basten, 2013), which usually compares the number of people aged 65 or over to the working age population (United Nations, 2001; Sanderson and Scherbov, 2010; Scherbov, Sanderson and Gietel-Basten, 2016). The common definition of working age is the 15 to 64 group (applied by UN database, World Bank database, Eurostat), but this gets criticised by some researchers from various aspects. For example, Basten (2013) suggests 20-64 as a more appropriate working age definition for industrialised Asian countries. Considering the definition of the “working-age”

in China, Hu and Yang (2012) propose the concept of “real old-age dependency ratio” that considers students of working age, unemployed, low-income employees and earlier retirees (before retirement age) to replace the widespread application of 15-64 as working age.

The definition and measurement of “simple old-age dependency ratio” (SOADR) are being widely challenged. The SOADR assumes that people aged 65 or over are dependent on the working age group. Muszyńska and Rau (2012) critique the SOADR for the sole concern on chronological age. Scherbov, Sanderson and Gietel-Basten (2016) argue that this assumption is based on the situations and understandings of ageing and dependency in the early 20th century, which is no longer applicable or even highly problematic to the current situation in either Western countries or East Asian countries. Characteristics of social settings (e.g. high rate of employment in the informal sector, diversities and various levels among older people, and female participation in the labour market) and changes in life expectancy and population health are suggested as reasons for why the current situation of ageing and dependency is different from that in the last century (Scherbov, Sanderson and Gietel-Basten, 2016).

Considering the application of SOADR in China, it is a debatable topic on whether it underestimates or exaggerates the severity of Chinese ageing. For example, Hu and Yang (2012) argue that the simple old-age dependency ratio neglects some important groups who do not contribute to the security system and thus underestimates the seriousness of the insufficiency of the pension fund in China. They suggest that the real old-age dependency ratio in China will increase under different conditions of family planning policies (see Section 3.1.2), as well as be much larger than that in Western countries, which indicates the “ageing population crisis in China” during the 2050s.

On the contrary, some researchers hold more optimistic viewpoints on the real old-age dependency situation in China. For example, the “prospective old-age dependency ratio (POADR)” is proposed as a new measurement to think prospectively rather than apply 65 as the fixed boundary to “old age” by taking changes in life expectancy into account (Sanderson and Scherbov, 2010; Scherbov, Sanderson and Gietel-Basten, 2016). The remaining life expectancy (RLE) applied in POADRs is commonly defined as 10 to 15 years. For example, Sanderson and Scherbov (2010) set the RLE of 15 years as a new measure for old-age, which



was the expected remaining life expectancy for 65 year-old people (fixed definition of older people in SOADR) in the 1960s in low-mortality countries. The POADRs measurement is applied for research analysis in the global context, including Europe (Muszyńska and Rau, 2012) and East Asia (Basten, 2013; Scherbov, et al., 2016). Exploring the old-age dependency situations in East Asia, Scherbov and his colleagues (2016) suggest China as a “middle-ground” country among East Asian societies (i.e. Taiwan, Macao, Hong Kong, South Korea, Japan, Mongolia, North Korea, and China). They also suggest that the increase of OADR in China is higher than most European countries.

In addition to the remaining life expectancy, other influential factors are taken into account in the analysis of old-age dependency, such as immigration and health conditions. For example, the amount of migration is suggested as an influential factor in the projection of OADR. The Federal Statistical Office of Germany (2015) calculates old-age dependency ratios under different hypotheses with the working age of 20-60 or 20-65 or 20-67 years combined with lower or higher immigration levels. Concerning the differences of the health situation between older people, Muszyńska and Rau (2012) propose old-age healthy dependency ratio (in good health and likely stay in the labour force) and old-age unhealthy dependency ratio (disabled or have chronic diseases and more likely to require external support and less likely to work) in European countries. Their study suggests that under the conditions of the inflow of migration, the improvements of health and reduction of disability risks will have positive impacts to compensate for the ageing labour force in Europe. With empirical and documentary data, Chapter 8 will examine the understandings of old-age dependency in urban China.

### *3.2 Market-Oriented Socio-Economic Changes*

Some researchers apply the term “Two Social Revolutions” to emphasise the influential status of the foundation of the People’s Republic of China (PRC) in 1949 and the socio-economic reforms in 1978 (Whyte, 2005). The developmental paths of the Chinese social welfare changed from the “over-equalitarianism” in the socialist Maoist era (1949-1978) to market-involved policies in the 1980s (Wu, 2004; Yang, 2006). After the “Cultural Revolution” that caused “ten years of political and social turmoil” from 1966 to 1976, the political environment

has kept relatively stable in China since the “Reform and Opening-Up” from 1978, during which the government allocated resources and attention to develop the economy. The market-oriented reforms contribute to the changes in the Chinese society in every aspect.

Socio-economic changes have impacts on the care system. For instance, the labour market reforms, housing marketisation, and rural-urban migration prompt the deregulation on the residential mobility of the working generation. The socio-economic reforms and other changes have changed household models as well as led to revolutions of the socialist welfare system in China (Whyte, 2005; Su, Hu and Peng, 2017). After rapid economic development since the “Reform and Opening-Up”, the Chinese government started to pay more attention to social development and welfare from the 2000s. These socio-economic changes also call for investigations on the reconstruction of the care system.

### 3.2.1 Pathways and the policy process of the marketisation reforms in China

The discussions based on policy phases or stages help the basic understanding of the policy process, which is valuable to examine the marketisation policy process in China. The policy process is a complex and multi-layered political process (Hogwood and Gunn, 1984; Hill and Hupe, 2003; Hill, 2013), during which decision-making and implementation are both multi-actor and multi-layer approaches (Gornitzka, Kogan and Amaral, 2005; Cerna, 2013). Hill (2013) identifies several typical stages in the policy process: getting issues on the agenda, policy formulation, policy implementation, and evaluation of outcomes. The policy process in terms of the marketisation is significantly rapid and compressed in a short period in China, showing in all typical stages (i.e. agenda-setting, policy-making, implementation, and the policy maintenance, succession, expansion or termination).

However, the “textbook categorisation” has been criticised for being rationalistic and unrealistic (Lindblom and Woodhouse, 1993; Hill and Hupe, 2003). Referring to the complexity of policy process in the care field in China, this thesis is strongly aligned with the argument of Hill and Hupe (2014) on the necessity to consider the wider contextualisation together with the idea of stages. Even though being divided into several stages, the continuum between policy formation and implementation is important in the policy process (Hill and Hupe, 2003). It is imperative to draw distinct characteristics of each stage and the

relationships between them. Policy implementation gap, in terms of the deficits or gaps between policy expectations and outcomes, is acknowledged as a widespread problem (Schofield, 2001; Hill and Hupe, 2003; Hill and Hupe, 2014). Chapter 8 will particularly discuss the importance of the policy implementation gap shown in the field of care for older people in urban China.

Referring to the policy-making and implementation process, the Chinese central government has applied “marketisation reforms” since the late 1970s across different fields (Wei, 2001; Wedeman, 2003). Based on the presumption that China cannot establish a communist regime for a long time (Central Committee of the Communist Party of China, 1987), the state suggested applying marketisation in a socialist context to deal with economic and social problems accumulated in the Maoist era (i.e. 1949-1978 socialist era).

In 1980, Chen Yun, a political leader of the central government in China, proposed that Chinese economic reforms should be in a way like “a person crossing a river by feeling his way over the stones”. This political idea implies the encouragement to explore the new and challenging field (i.e. socio-economic reforms) with steady steps (consciously) and courage (boldly). Deng Xiaoping, who set up the market-economy and “Reform and Opening Up” in China in 1978, agreed with this suggestion and emphasised China’s process of reforms and the modernisation as crossing a river by feeling the stones. The state acts as the builder in the extensive marketisation process in China (Zhang, 2006).

In that era, the Chinese government enacted policies with little practical experience in a very compressed period, which valued the speed of reactions more than the persistence or potential outcomes of policies. This political philosophy has been embedded in the policy-making and implementation in China until now, and has influenced viewpoints and experiences of policymakers, implementers, practitioners and the public across different fields. Little evidence from research or practice has been involved in the process. For example, Cheng (2014) proposes the process of medical insurance system reforms in China: the central government chooses several local sites for pilots, summarises experimental experience, and spreads good practice and calls off unsatisfactory schemes.

Following the market-oriented economic reforms, China is gradually applying market mechanisms in social policy across various fields (Guan, 2000), such as housing (Wu, 2001; Zhang, 2006), education (Ngok, 2007; Mok, Wong and Zhang, 2009), social protection (Zhu and Nyland, 2004), labour market (Zhu and Nyland, 2004), social organisations (Saich, 2000). On one hand, the marketisation improves the delivery of public services (Li, 2013a), through fulfilling individuals' needs, enhancing efficiency and competition. The application of market mechanisms in these sectors entails both the state and the market playing an active role. On the other hand, economic reforms and the marketisation process challenge the public service allocation and the social protection system (Nielsen et al., 2005). Negative outcomes have been identified through the marketisation process, such as unclear objectives of the marketisation, insecurities (Nielsen et al., 2005), inequalities and disparities (Ngok, 2007; Mok, Wong and Zhang, 2009). In contemporary China, the marketisation is an inevitable trend for the social welfare sectors.

### 3.2.2 Reforms of the labour market and job-based welfare system

The labour market reforms involve the increase in female labour participation, changes in the job-based welfare system, and rural-urban working-age labour migration. First of all, increasingly, women got involved in education and the labour market in China after the 1980s. In the past, most caregivers for older people were female family members. Increasing female labour participation reduces the number of familial caregivers. Since more women go outside of the house for paid jobs, external help is needed to take the direct care responsibility for their older family members.

In urban areas, based on the traditional family-centred care system in China, state-owned enterprises (SOEs) had joined in to take "cradle to grave" responsibility (e.g. jobs, housing, social services) for their employees before marketised reforms in the 1980s (Zhou, Liu and Kwan, 2016). The transition phase started from the 1980s, when the informal care market started to support families in the context of decreasing the paternal role of SOEs as the "work unit (*danwei*)". SOEs encountered challenges during economic reforms, which caused millions of lost jobs and job-based benefits (e.g. health care and retirement benefits) (Gold et al., 2009). According to Whyte (2005), both young and older people in urban China met problems

of the reduction in pensions, medical insurance, and other benefits. Besides, house prices increased dramatically due to the marketisation of public housing schemes after the reforms of SOEs.

During reforms in the job-based welfare system for urban residents since the 1990s, the care responsibility has shifted from the state and SOEs to individuals and the market. During the golden period of SOEs (1950 to 1979), jobs for urban youth were usually allocated by the state in the same SOE where their parents worked or at other factories close to their parents' work units (Zhou, Liu and Kwan, 2016). Housing and other benefits were also allocated by work units to all workers (Zhang and Rasiah, 2014). After the reform, the allocation of jobs by the state transferred to a more open labour market. Reforms of the labour market and the housing marketisation led to the increase of the living distance between older people and their adult children, which reduces the convenience for adult children to provide care to their parents.

### 3.2.3 Pension system reforms and financial support for older people

Facing the rapid ageing trend and the increasing dependency rate, the pension system in China encounters significant challenges. The Chinese pension system has been at a re-establishment and adjustment stage to restore the pension system through coordinating allocation and funding since the 1980s. After the reforms in recent decades, China has constructed a basic multi-level pension system by creating the provident fund, changing the pension calculation methods, and establishing the basic pension mechanism. The current pension system in China is primarily "pay as you go" based and supplemented by private account pensions. Even though the pension system has become multi-source and systematic, whether retired people have sufficient pension to cover the cost of care is still questionable for the substantial proportion of older people in the population.

Specifically, the current pension system contains three types of insurance, namely, basic pension, enterprise complementary pension, and private pension. First, the basic pension is compulsorily implemented by the state to ensure the basic living condition for retirees, which in theory covers all workers, freelance and individual businessmen in urban areas. By 2010, there were 256,730,000 people involved in the basic pension system in urban areas (National

Bureau of Statistics, 2011). However, the payment of basic pension is insufficient to “cover basic living requirements”, especially when older people are in need of purchasing care services from the market.

Second, the enterprise complementary pension aims to enhance the living quality of their employees after retirement by extra investment in addition to the basic pension. The enterprise complementary pension is a type of private account. By 2010, 371,000 enterprises established complementary pensions, with 13,350,000 workers involved in the complementary pension system (National Bureau of Statistics, 2011). Third, the private pension is a voluntary and personal choice of investment to ensure individual income after retirement. The enterprise complementary pension and private pension imply inequality between pension income after retirement from different enterprises and personal investment during working age, which have impacts on the ability of different groups to obtain care in the market.

Diverse types of pensions have led to some progress in involving more people in the pension system, but the coverage is still limited. According to Hu and Peng (2012), 257 million urban residents attended the pension system in 2010, representing 18% of the whole population. A large number of older people have to rely on their own savings or their children after retirement or when they are not able to work anymore (e.g. farmers, freelance). The “New Pension System for Rural Residents” has been conducted since 2009, and covered 180 million rural residents (24% of the rural population) by 2010 (National Bureau of Statistics, 2011). The number of residents (including rural and urban) in the basic pension system had reached 512,550,000 by 2017 (Ministry of Human Resources and Social Security of China, 2018).

The expenditure on public pension and social security programmes consists a small portion of the gross expenditure of the state. According to the National Bureau of Statistics of China (2017b), China’s social expenditure consists of 11.5% of GDP, which is much lower when compared to welfare states. For example, the percentage of “social spending” (comprising cash benefits, direct in-kind provision of goods and services, and tax breaks for social purposes) of GDP is on average 21.0% in OECD countries, among which the percentage of social expenditure was 31.5% in France, 21.5% in the UK, and 10.4% in South Korea in 2016

(OECD, 2018). In this context, there is a widespread argument in China that the state and social security system ought to increase financial support to older people. For example, Du and Tu (2000) suggested that the state should take more care responsibilities for older people in the finance dimension.

Nevertheless, financial support for older people still relies heavily on themselves and families (mainly adult children). The “Chinese Residents’ Life Quality Index Survey” (Horizon Research Consultancy, 2010) suggests that 37% of Chinese residents treated pensions from the state (basic pension) or “work units” (enterprise complementary pension) as the most reliable source of income for older people, while 35% of participants indicated that they would rely on their children or other relatives for financial and personal care. Based on data from the “China Longitudinal Ageing Social Survey” conducted in 2014, Sun (2017) argues that the net financial support provided by adult children (deducted financial support transferred from older people to their children) plays a vital role in older people’s lives, which is significantly higher in rural areas than in urban China.

In addition to the shortage of pensions, severe risks in the Chinese pension system are identified. In the context of ageing and the decrease of the working age population, contributions of the working-age group into the pension funds show a growing deficit when compared to the allocation of pensions to older people. The pension deficit will dramatically enlarge due to the large population and rapid ageing. The deficit risk and existing problems embedded in the pension accounts has been a public concern regarding the Chinese welfare system in recent years.

#### 3.2.4 Cultural norms on the family-centred care system

The family has a supreme position in the care system in both care provision and finance dimensions in China. Family care provision for older people in China involves children (both daughters and sons, but traditionally allocating more responsibility to sons) and extended families. Relying on adult children for care is a continuous phenomenon based on traditional family norms (Ochiai, 2009). Even though the increasing dependency challenges the traditional family-centred care provision for older people, filial support still plays an active role in China (Feng et al., 2012). Hu and Peng (2012) compared the percentage of Chinese

older people who are living alone with other societies: only 10% of older people in China lived alone, which was lower than the average level of 22.5% in developed countries and the world average level of 14%. According to Hu and Peng (2012), 75% of older people lived with their adult children or spouses. Among the group of people who are aged 80 or older, the percentage of living together with adult children was nearly 90%.

However, the living arrangement of older people has been influenced by demographic changes of ageing and migration. Chinese families encounter challenges in taking the care responsibility for older people (Hu and Peng, 2012). Socio-economic changes lead to the emergence of the “empty-nest” family model in which older people are living alone (without adult children but including older couples) (Jing and Chen, 2009). According to the China National Working Committee on Ageing (2010), the “empty nest” family represents 54.0% in urban areas and 45.6% in rural areas of China with an overall percentage of 49.3%.

Whyte (2005) illustrated that cultural diffusion and government policies on family planning have impacts on individuals and families by altering their values and ideas, which then lead to changes in their behaviours. Consequently, changes in behaviours (e.g. the living arrangement and household structure) also lead to changes in values (public attitudes towards care arrangements), which are shifting from practising personal, financial, emotional “filial piety” in comprehensive care to older parents to less strictly. Prior to the 1990s, care provision for older people mainly relied on their families, while the state tried to provide public support to the childless group (Zhan, 2013). As Lavelly and Ren (1992) argued, around 80% of older people lived with their children in the 1980s. Concerning the living arrangement since the mid-1990s, older people in urban China are more likely to live in nuclear households instead of extended families (Whyte, 2005).

In the changing living arrangement context, the function of families for care provision has gradually degraded. Families need external support to deal with the challenges of rising care needs and decreasing number of children as caregivers. In terms of direct care providers in urban areas, care workers are replacing family members in care homes or older people’s own homes. Even though the direct care provision is decreasing, families keep providing financial support to the older people. According to Phillips and Feng (2015), although the role of



families in long-term care is weakening in China, families still provide important social and financial support to older people.

In brief, even though the Chinese culture values the role of families in caring for older people, it is becoming difficult for adult children to independently take the care responsibility due to the significant demographic and socio-economic changes. As argued by Hu and Peng (2012), care provision for older people is changing from a family responsibility to a social issue in the context of rapid ageing and transformation of the household structure. The lack of social service and the reduction of the informal caregivers present a significant challenge to the care system in China.

### *3.3 Regional Disparities and Rural-Urban Migration*

Care provision and finance for older people are provided differently in urban and rural areas in China. Differences in care for older people between rural and urban areas are embedded in significant disparities in the economic background of individuals and their families and welfare systems, which is gradually being influenced by rural-urban migration as well. This section describes regional differences in economic background and welfare system in the first part, while rural-urban migration and impacts on the care system in the second part.

#### *3.3.1 Differences in socio-economic backgrounds & double-track welfare system*

The Chinese household registration system (*hukou*) classifies rural or urban *hukou* and further by specific location of origin. *Hukou* system was established in the 1950s and is still strongly related to socio-economic rights and privileges based on the registered location (Whyte, 2010; Wang, Piesse and Weaver, 2011; Zhang and Treiman, 2013). In the context of high control of household registration, rural residents are generally more disadvantaged in terms of the economic backgrounds and the access to welfare provision (e.g. health care, pension) than their urban counterparts. The following parts demonstrate rural-urban differences in ageing and the “double-track welfare system”, family support and care provision, and market-oriented reforms.

Different processes of population ageing and the “double-track welfare system” are present in urban and rural areas. Du and Tu (2000) argue that different living conditions of older

people reflect significant rural-urban disparities in fertility rates, mortality rates, geographical background, and socio-economic development. Over 20% of the local population are aged 60 or over in cities like Beijing, Shanghai, Suzhou, compared to the national 14.9% (Lu and Yang, 2014). Referring to the financial income of older people (see Section 3.2.3), pension systems and payment levels are different in urban and rural areas. Knight, Li and Song (2006) suggest that rural-urban disparities not only represent in income, but also in education, health care and housing. What is more, “structural imbalances” (Mi, 2014) might be reinforced in the context that local governments are playing a dominant role in the care system.

Meanwhile, there are regional disparities of family support level between urban and rural areas. Urban residents have more access to resources from the state and the market than their rural counterparts. The improved financial conditions of urban families make the employment of care workers comparatively affordable. As Ma and Zhou (2011) argued, the dependency of older people on their families is generally higher in rural areas than in urban China: the majority of older residents in cities live on their pensions, while more than half of rural older people rely on family support and around 40% of older people in rural areas depend on their own labour (e.g. farming). According to the 1% of the whole population survey in China in 2005, around half of older people living in small towns or rural areas relied on family support as the main source for living.

Referring to care provision, the employment of care workers replaces a part of familial caregiving in urban China. As briefly discussed in Chapter 1, three main reasons are identified based on different arguments on the rationale behind the employment of care workers in urban areas. First, fewer adult children are available to provide care for older parents due to the stricter “one-child policy” in urban areas (Zhan, 2013). Especially for urban residents working in SOEs, they had the risk of losing their jobs as punishment for having more than one child. So, the size of urban households is generally smaller than those in rural areas. Second, the female participation in education and the labour market in China is higher for urban residents than their rural counterparts. Third, urban families have gained benefits and improved their financial background in the context of economic reforms, which makes the employment of care workers comparatively affordable for them.

Generally, the development of care for older people in urban areas is earlier and faster than in rural China in this extensive marketisation context (see Section 3.2.1). The policy priorities and investment of central and local governments are urban biased (Wang, Pisesse and Weaver, 2011), focusing on developing the urban economy and benefiting urban residents (Knight, Li and Song, 2006). Even though rural residents get more opportunities in the market-oriented reforms than before, the developing speed is much slower than in urban areas, which in turn has led to the significant increase of economic disparities (e.g. household income) in recent decades. Despite the rural-urban inequality, this thesis focuses on the marketisation of care in urban China since the marketised strategies are widely applied in urban areas.

### 3.3.2 Rural-urban migration

Rural-urban migration in China's context implies the rural labour force migrating to urban areas in search of a better income. More specifically, rural migrants have physically moved out from their hometown to participate in socio-economic activities in urban areas without urban household registration (*hukou*) (Meng, 2000; Whyte, 2010). Rural-urban migrants are also defined as "Floating Population" (Sun, 2000) to represent their characteristics of the high mobility and non-bounded urban household registrations. Rural-urban migration is commonly defined as "floating" or "temporary" because the residence location of migrants has changed to urban areas but their household registration (*hukou*) remains in the rural hometown (Li and Siu, 1997; Chan, Liu and Yang, 1999).

Internal migration becomes popular in China in the context of significant rural-urban economic disparities and gradually supportive migration policies (migration was strictly controlled during 1958-1978). When state restrictions on migration were released in the socio-economic reforms after the 1980s, income and other socio-economic disparities attracted rural residents to move to urban areas. The internal migration in China represents a mainstream direction from poorer areas to comparatively richer areas, which specifically concentrates on the geographically eastern coastal areas and urban areas (Peng and Guo, 2000). As investigated by the National Bureau of Statistics of China (2017c), around 281,710,000 rural migrants went to urban areas for employment purposes in 2016. Yet, as

Knight, Li and Song (2006) argued, the Chinese government retain high control over the rural-urban migration, which impedes rural-born people to gain permanent urban residence.

Rural-urban migration inevitably influences care provision for older people in China regardless of input or output areas, which contributes to the increasing rural-urban disparity of care for older people. On one hand, migrant workers play a key role in the labour market in urban areas, especially significant in the care labour supply. In the context of huge demands of care workers, increasing rural-urban migrants are undertaking the care work for older people in urban China. The National Bureau of Statistics of China (2017c) suggests that the biggest groups of rural migrants worked in the industries of manufacturing (30.5%), construction (19.7%), wholesale and retail trade (12.3%) and the service sector (11.1%). The crucial role of migrant care workers in the marketisation process of home care is discussed in Chapter 7.

On the other hand, the outflow of migrant workers has negative impacts on care provision for rural older residents. Due to the large amount of youth migrating out to urban areas for jobs, there exists a care gap for their older parents who are left behind in rural areas. Unlike increasing employment of care workers, rural older people exclusively receive care from extended family members or suffer without any support. Cai, et al. (2012) suggest that differences in the access and coverage of pension systems is one important reason for the situation that rural residents rely more on families than urban counterparts. The gap of care for “older people who are left behind” focuses on negative outcomes of the large output of working-age migration in rural China, which is one of the hot research topics in China. Yet, this thesis exclusively focuses on the research gap of the marketisation of care in urban China.

### *3.4 Home Care in the Chinese Care Regime*

The definition of home care has no consensus in policy and practice in China. The existing definitions of different care arrangement methods are blurred and sometimes overlap, especially between home care and community care. For example, “elderly home care in the community” proposed by the Shanghai government in 2010 includes care received at home and accessible in the community. Chen and Huang (2012) propose the idea of “home- and community- based care services for older people”, which combines care provided either at

home or in the community. Jing and Chen (2009) propose the idea of “integrated home care”, which focuses on developing intergovernmental coordination in the field of care for older people. Ding (2013) argues that home care in China combines care provided by diverse sectors, including families, the market, and the society.

To make the concept of home care clearer, I define “home care” as care delivered to older people in their own homes by care workers or a mix of care workers and family members, including mixed types such as personal care (e.g. nursing), practical care (e.g. cooking, shopping, cleaning) and emotional support. Two main characteristics are emphasised in this definition to differentiate home care from other care approaches. First, “home care (*jujia yanglao*)” is differentiated from “family care (*jiating yanglao*)” based on whether there are services purchased from outside of families or not. It is stated in several policy documents (see Section 3.4.2) that family care is exclusively provided by family members, while home care involves paid care services. Second, home care is distinguished based on the locations where older people get access to care (in older people’s own homes) when compared with community care (at day-care centres or other institutions in the community) and residential care (in care homes). Chapter 5 will justify this definition of different care approaches with in-depth analysis based on documentary and empirical data. This section describes policy and practice in terms of developmental paths of the care system and home care in urban China.

#### 3.4.1 The developmental paths of long-term care policy

The care system has changed since the “Reform and Opening-up” in 1978 (see Section 3.2). As discussed in previous sections, the unprecedented demographic and socio-economic changes challenged the care system and pushed it to reform. The state, SOEs, families, and social organisations played new roles during this transition process from the “state welfare model” to the “socialisation of social policy” (Guan, 2000). Besides, globalisation also pushed the sudden burst of marketisation of care in China (Ochiai, 2009). Care provision for older people in urban China starts to turn from traditional family care that casts exclusive responsibility on family members or the SOE-based security system to the new model of home care with the mixed responsibility of families, the state, and the society.

The role of the state in China has been changing since the socio-economic reforms of the 1980s but has kept its dominant status in the care regime. The construction of the Chinese home care system is dominated by the state (Jing and Chen, 2009). The Chinese government claims to have changed from the overarching paternal state to be more active in monitoring, regulating, and providing financial support rather than the direct provision in many fields. The central government policy document of *“Guidelines for Comprehensively Promoting Home Care Services”* (China National Working Commission on Ageing, 2008) points out that the role of government is to establish strategic plans, provide land and facilities, finance investment, set up standards, and monitor and evaluate the care delivery instead of directly providing services. Jing (2009) suggests that contracting out some services to private institutions is a reasonable choice for the state in the trend of shifting from a “big state” to a “small state” or “indirect state”.

After a period of exclusive focus on developing the economy from the 1980s, the welfare topic was taken back to the political agenda in the 2000s. The Chinese government started to enact laws and policies to construct the care system, including *“Accelerating the construction of care provision system for older people”* (State Council of China, 2006a), *“Guidelines for Comprehensively Promoting Home Care Services”* (China National Working Commission on Ageing, 2008), *“Twelfth five-year plan of national economic and social development”* (State Council of China, 2011), *“Construction plan of social care for older people (2011-2015)”* (Ministry of Civil Affairs in China, 2011a), and the *“Report on the 18th Communist Party of China National Congress”* (Central Committee of the Communist Party of China, 2012) delivered by Hu Jintao to “Firmly march on the path of socialism with Chinese characteristics and strive to complete the building of a moderately prosperous society in all aspects”.

Regarding the location for older people to live or receive care, the majority of older people in China remain living at home to receive care services instead of moving to residential institutions. The large ageing population in China makes it impossible to provide residential care to a considerable proportion of older people. According to the Ministry of Civil Affairs (2017a), the quota of residential beds for older people was 31.6 beds per thousand older people in 2016, which had increased by 4.3% compared to 2015, but still at a low level. Within

the limited resources and residential facilities, the Chinese government has recognised the irreplaceable importance of home care in the care system. Home care is suggested as an appropriate approach for China to meet the dramatic demands on care provision (Jing and Chen, 2009). According to the *“Chinese Family Development Report”* (National Health and Family Planning Commission of China, 2015), 90% of older people in China receive care at home (either provided by family members or care workers). Based on the retrograde traditional family care and insufficient residential care, home care is inevitably applied by a larger number of older people for care arrangements in urban China.

In this context, the Chinese government started to introduce policies to develop home care in urban areas from the late 1990s. China National Working Commission on Ageing (2008) emphasises the central status of home care in the care system. The Ministry of Civil Affairs (2011a) issued *“Construction plan of social care for older people (2011-2015)”*, suggesting that the Chinese care system consists of home care, community care, and residential care, among which home care is the foundation of the care system. It is also argued that home care would be the priority in developing care for older people. As Ding (2013) suggested, home care is the base of the care system in China, which complies with the willingness of older people and makes the best of joint responsibility of the family, the society, and the state. Clarified in Hu's report at the 18th Communist Party of China National Congress (2012), the state would develop care services and care industries to deal with the population ageing “problem”. The *“Twelfth Five-Year Plan of National Economic and Social Development”* for the period of 2011 to 2015 proposes to combine the family, the community, and welfare institutions to promote the marketisation of social welfare.

Presumably, home care is important because it is aimed to be used by the majority (i.e. commonly cited as 90% by policy documents) of older people to receive care in their own homes. The State Council of China (2013) proposes three principles for developing home care as the basis of the care system: first, the state encourages self-support and support from families and the community for home care, during which families are still the main supporters of older people; second, home care is the main approach for care, while community care and institutional care are supplements in case home care is too difficult to manage; third, families

take the main caring responsibility for older people, while the state and the society provide extra support. Referring to the cultural tradition and the current policy direction, families are still in the core position of providing direct care and financial support to older people.

Even though it is a popular view to support families in care provision, neither the central government nor local authorities have put home care as a priority. Specifically, Song (2014) argues that home care has received less financial and policy support from the state when compared to residential care and community care. Instead, governments at different levels have issued a number of policies to encourage older people to stay at home for care with external support outside of families, moral support and obscure promises to increase financial support (no detailed budget or funding attached). Unfortunately, the number of home care agencies has not been included in the statistical report of the Ministry of Civil Affairs or other government departments.

Considering the strategies for constructing the care system in the marketisation context, the State Council of China (2006b) emphasises that the state will contribute to care for older people under the principles of industrialisation and marketisation, establishing fair and standardised regulations for admittance, encouraging the coordination of public and independent providers, and promoting the funding into the field of care for older people through various ways. The specific types of funding matrixes and coordination methods between independent providers and governments will be discussed in Chapter 6, which illustrates marketisation strategies applied by the state in the care field in greater detail.

During the Twelfth Five Year Plan period (2011-2015), trials have been conducted in many cities to develop the care market and coordinate different stakeholders, especially in developed areas like Beijing, Shanghai, which will be discussed in the following part. Based on collective experiences in these years, the State Council of China (2016b) started to take further action on developing home care and community care (i.e. the starting year for the Thirteenth Five Year Plan). The Chinese central government enacted a few important policies in 2016 in terms of home care for older people, such as “Central financial budget will support the trials of home care and community care for older people” (Ministry of Civil Affairs & Ministry of Finance, 2017), “Comments on the comprehensive opening-up of the care service



market & improving the quality of care services” (State Council of China, 2016a). The Ministry of Civil Affairs (2016) selected 26 cities from 23 provincial divisions (the administrative divisions at the provincial level in China are attached in Appendix 1) for trials of reforms of home and community care.

#### 3.4.2 Home care practice in urban China

The market is increasingly involved in care provision in China. Strategies of the marketisation of care (see Chapter 2) have started to be implemented in urban China during the trials to develop home care and community care. The market-oriented policies (e.g. contracting out services to independent providers, cash for care, and subsidies) are applied in trial schemes to encourage the participation of diverse social resources (e.g. private providers, non-government organisations). Zhan, Feng and Luo (2008) identified three types of care institutions in China: government owned, community owned, and privately owned. Many public welfare institutions in China increasingly transform into non-state institutions (the definitions and categories of non-state agencies will be illustrated in Chapter 6). Some care agencies are still partially funded by the state, while most of them have started to combine funding from diverse sources of public funding, individual investments, charity donations, and user fees.

As mentioned in Chapter 2, early in 2000, the Civil Affairs Bureau in Shanghai conducted small-scale home care projects in purchasing care services and constructing care facilities (e.g. community day-care centres, offices for home care agencies). Following the trials in Shanghai, many cities have started trials of home care for older people. For example, Changsha (the capital city of Hunan province) conducted a scheme in one community (*shequ*) in 2006 by providing vouchers to older people for purchasing care services in the day care centre or “door-to-door” care services delivered to their own homes.

Home care practice involves the coordination of different government departments and different levels of government. For example, the local government of Jing’an District in Shanghai started a home care project for older people in 2007, in which the state paid fees for home care services for older people. Considering the content of home care services, Jing (2009) suggested that “meal help” was the main service of home care trials, combining local

governments (*jiedao*), the market, the family, and the community. “Meal help” might have been the mainstream of home care services at the time of Jing’s study in 2009. With the rapid development of home care in recent years, I found diverse types of care services other than meal help being included in the home care package in the fieldwork (see Chapter 6). Even though it is no longer the mainstream type of home care service, the analysis of different models of “meal help” provides interesting insights for home care research.

Specifically, two types of “Meal Help” were identified in Jing’an District of Shanghai, namely, the community model and the market model. This community model relies on existing social capitals (i.e. care homes, hospitals, universities, and hotels) in one neighbourhood. Meal providers in the community model were organisations persuaded to join by local governments; deliverers were community centres monitored by the District Committee of Ageing Affairs, in which most employees are “40/50 people” (laid-off workers because of state-owned enterprise reforms: females aged 40 or over and males aged 50 or over). The community model asks for less starting-up cost, while the state finds it easier to inspect through the existing network. Jing (2009) argued that the community model is generally limited in size (sticking to one jurisdiction/neighbourhood), qualification (non-professional organisations), stability (providers might easily turn to their principle work or other fields), as well as gets highly influenced by authorities and bureaucratic barriers.

In the market model, the state encourages independent organisations to produce and deliver meals to older residents according to guidelines set by the state. The market model is applied with emphasis on the improvement of efficiency through the competition among providers. For example, in Jing’an district, a non-governmental organisation (NGO) named “Meal project for older people office” worked as the media between the state and the market in taking “meal help” projects. As Jing (2009) predicted, the market model would be more widespread in the field of home care for older people in urban China.

Referring to the financial support provided by the state, independent organisations could get tax concessions when purchasing estates, deducted rates of bills (e.g. water, electricity, gas), and interest-cuts or interest-free when applying for loans with the purpose of investing in the care field. Both home care providers and service users have access to subsidies provided by

the government in Shanghai: care providers could get a fixed allowance based on the number of services they have provided; older people get subsidies to purchase care services or services provided by accredited providers based on assessments of their physical and mental conditions.

During the process of developing home care, central and local governments gradually take their duties in setting up standards and regulations of services and inspecting and monitoring behaviours in the home care market. For instance, the municipal government of Ningbo (a city in Zhejiang Province) established local regulations on home care for older people in 2008, to standardise the basic requirements of different types of home care services. With experiences in contracting out home care projects since 2003, the Xuanwu District of Nanjing (the capital city of Jiangsu Province) established a home care assessment centre in 2008 to keep the inspection process independent from the government and open to the public. In terms of the care labour recruitment, the Ministry of Civil Affairs implemented several policy documents in terms of occupational standards for care workers in the care sector in the past decade, allowing the care industry associations and provincial labour departments to set local standards for training, assessment, and accreditation.

Comparing the developmental care policy and practice, I hypothesised that the market acts quicker than the state, whereas local governments in highly marketised jurisdictions like Shanghai apply marketisation strategies earlier than the policy-making of the central government and actions in other areas. More specifically, market participants in big cities joined in practice without a systematic framework or policies at the first stage. The voluntary development of the care market and following actions taken by local governments are much more advanced than policy-making of the central government or province/municipal governments. Local governments started to conduct trial schemes (with discretionary power accredited by the central government) after the importance of home care had been realised. Later, the central government stepped in to design the legal framework and make policies. Yet, the process in the real world is not in the simple linear way. Chapter 8 will discuss the policy-making and implementation process in the field of care for older people in China in greater detail.

### *Conclusion*

This chapter has discussed the context of home care for older people in urban China. It has identified influential factors and the interrelationship between them, including demographic changes, socio-economic changes and market-oriented reforms, rural-urban disparities, and home care policy and practice.

Care policy and practice for older people in China have been in need of reform since the 1980s as a result of dramatic demographic changes and socio-economic changes. The unprecedented scale of population ageing raises a huge amount of care needs. Families, the traditional care providers, cannot bear the increasing care provision responsibility. It is an urgent task for China to figure out how to address the care deficit. With regards to the disparities in the care systems in rural and urban areas, evidence shows that the marketisation of care has taken place in urban China in recent years, which provides a strong rationale for my choice of case study.

However, there is a gap in the knowledge of the marketisation of home care in China. The home care market has not received enough attention in research. Many researchers focus on community care or the care deficit or left behind older people in rural China. The marketisation process of home care in urban China has not been systematically analysed in research. What is more, there is little assessment of the outcomes of the marketisation processes. In order to address the research gap, the empirical fieldwork explores the processes and outcomes of the marketisation of home care in urban China based on the case study data collected in Shanghai.

## Chapter 4 Methodology

---

### *Introduction*

This chapter describes the research design of the thesis. In the first section, it explains the methodological and epistemological approach applied in my research. The second section begins with a justification of why and how the case study approach was employed and then describes the data collection process for interviews and documentary and secondary data. The third section illustrates why and how the approach of thematic analysis was applied for organising and interpreting the data. The fourth section addresses the ethical issues of the fieldwork and how these were addressed. Before the conclusion of this chapter, the fifth section reflects the limitations embedded in this study from the methodological perspective.

### *4.1 Methodological Approach*

The methodological approach of this thesis is determined by its focus on the marketisation process of home care policy and practice in urban China. I examine how the role of the market is shifting; how the other sectors respond to these changes; and how the care regime is shaped and, in turn, shaping the care policy and practice.

I employ qualitative methods based on the exploratory research question, which reflects the gap in the understanding of the marketisation of care in China. The qualitative research approach matches my research aims, because this design provides “an in-depth and interpreted understanding of the social world, by learning about people’s social and material circumstances, their experiences, perspectives and histories” (Ritchie et al., 2014, p.23). Among key stakeholders in the care market (see Chapter 1), namely service users, providers, purchasers, care workers, and regulators, central to my study are the experiences and viewpoints of care providers and local government officials. These two target groups have first-hand information about how home care agencies are organised, how government policies are implemented, and what kind of marketisation processes are proposed. The sampling approach is explained later in Section 4.2. Even though care providers and local government officials are active participants in the care market in urban China, their ideas and experiences are absent in existing research. Through a focus on their perspectives, this thesis

produces valuable findings of the role of these stakeholders in the policy process (see Chapter 8).

With qualitative methods, I am able to examine the experiences and viewpoints of important stakeholders in the field of home care and interpret the processes and outcomes of the marketisation of care in urban China. The merits incorporated in qualitative research (e.g. context information, in-depth responses, and flexible designs) are represented in my study. For example, the background information of care agencies and government departments, personal stories and in-depth viewpoints about the care market, and flexible follow-up questions based on their responses, give me insights into how individual agency is operating in the care market, how care providers and local government officials understand ageing and care in their areas, and further elaborations on unclear or interesting points. From data collection to data analysis, the qualitative study emphasises the processes, views, and meanings of the experiences of participants. The holistic and in-depth data are vital for my interpretative analysis.

Quantitative methods are valuable for analysing the marketisation trend with numerical evidence, such as the financial investment of governments and individuals in home care, numbers of for-profit and not-for-profit care providers, sizes and profit analysis and cost budget data of care providers. However, the relevant statistical data in the field of care for older people is not available in China, which is also difficult for me to collect individually. Thus, my ambition to apply mixed method was restricted due to difficulties in collecting quantitative data in the field of care for older people in urban China. Nevertheless, as Bryman (2007) argued, methods combination is not inherently superior to single method research. The in-depth qualitative methods and relevant merits match my research objectives to explore and interpret the process of marketisation of care in urban China.

Regarding the process of the qualitative research, an inductive and interpretative approach is applied. For the former, this qualitative study employs the inductive approach to develop general themes on how the marketisation of care develops in urban China based on interviews with care providers and local government officials who work in the field. As the common process illustrated by Creswell (2014) for qualitative approaches, my thesis involves

emerging ideas, data collection within its natural settings, inductive data analysis, and my interpretations of the meaning of data.

For the latter, the epistemology adopted by this research is based on interpretivism, which is widely applied in qualitative research. The interpretivist approach relies on the understanding of reality and objects as well as the reflection and interpretation of researchers. Interpretivists assume that the social world needs to be explored through the perspectives of participants and researchers to provide the “meanings” rather than “causes” of the social phenomena (Ritchie et al., 2014). As Bryman (2007) argued, the emphasis of the interpretivist approach is on the understanding of behaviours and interactions. Applying the interpretivist approach, this thesis reflects and interprets the construction of the social background and interactions of different participants (e.g. care providers, service users and purchasers) in the field of care for older people.

## *4.2 Data Collection*

A case study approach is used to examine multiple perspectives on the marketisation of care in the context of Shanghai. The main data source derives from semi-structured interviews with owners and managers of home care agencies and government officials at the community and sub-district levels. Relevant policy documents, secondary data, and existing academic literature have been collected to support the analysis of policy priorities and development directions of care for older people in urban China.

### *4.2.1 Case study approach*

#### *Justification of case study*

The case study approach was chosen based on my exploratory research questions. It provides a full account of holistic views and contextualised understandings from different perspectives, which contributes to the theory application (Berg, 2007; Lewis and Nicholls, 2014). I have achieved an in-depth and holistic understanding of the development of care market through the application of the case study approach.

Considering the unit of analysis for the case study, it could be analysed based on projects, events, processes, individuals, corporations, or comparisons (Berg, 2007; Creswell, 2014). My study includes several levels of units of analysis: first, the basic analysis units are individuals who are active participants in the field of care for older people in Shanghai; second, I use processes (of the marketisation of care) and geographical cases as analysis units. In the empirical study, I collected a variety of data with detailed information for the case study in the geographical area of Shanghai, by visiting individual participants of care providers and local government officials.

The case study could be very complex in practice. As Lewis and Nicholls (2014) argued, it may involve comparisons between cases, between different actors in one case, and between groups of individuals across cases. I select Shanghai as the geographical case at the first level; sub-district governments (with its subordinates at the community level) and home care agencies as the institution case at the second level; and individual participants as the basic level. I compare actors within each institutional case (e.g. managers in one care agency), between cases (e.g. representatives from different agencies), and between groups across cases (e.g. owners, care managers and marketing managers from different care agencies). In short, this is a case study about the care market development in Shanghai, with individual cases of care providers and local government officials.

To capture the holistic picture of the marketisation of care, the case study design necessarily calls for the presence of researchers in the research context to collect in-depth data (Creswell, 2014). I went to Shanghai for the pre-fieldwork in August 2015 and the formal data collection from February to May in 2016. With the pre-fieldwork, I conducted a primary exploration of the research context and communicated with a few potential participants. As Lewis and Nicholls (2014) suggested, the early understanding of background information contributes to the design of case selection criteria and the categorisation of cases. I discussed with a small number of Chinese academic staff and managers of home care agencies on the topic of the marketisation of care and my empirical research proposal during the pre-fieldwork. These conversations gave me insights into the context of care for older people in urban China and the key stakeholders in the care market in Shanghai. The pre-fieldwork also offered me



valuable contact information and work connections that assisted my recruitment of interviewees (see Section 4.2.3).

Based on the early understanding of policy and practice contexts of care for older people in Shanghai, I decided to involve care providers and local government officials as the key participants of my research and set up the preliminary case selection criteria, so as to explore different perspectives in specific contexts with the case study. As Lewis and Nicholls (2014) argued, different perspectives may derive from different data collection methods or multiple accounts of individuals who hold different perspectives on the research topic. On one hand, this thesis involves multiple data extracted from interviews, secondary data, policy documents and literature to explore the development of care for older people in urban China. On the other hand, interviews in each category also show points of view about the marketisation of care from different perspectives.

#### *Case location*

With 2,990,200 (20.62% of the population) people aged 65 or over and significantly marketised home care provision for older people, Shanghai is one of the most rapidly ageing cities in China (Shanghai Municipal Statistics Bureau, 2017). Unsurprisingly, the Shanghai government gives priority to developing care for older people. Regarding the relationship between demographic changes at the national level and municipal level, Guo and Li (2010) argue that Shanghai's demographic changes (e.g. ageing, migration) show the development trends and the national population prospects in China.

The marketisation level in Shanghai is one of the highest among all provincial governments in China (see Appendix 1). For instance, the "marketisation index" in Shanghai keeps ranking one of the highest among 31 mainland provincial divisions, which is measured by indicators of the relationship between the state and the market, non-state-owned economy, factor market, product market, and market intermediaries and legal environment (Fan, Wang and Zhu, 2011; Wang, Fan and Yu, 2017). The GDP per capita in Shanghai (¥97,370 RMB, equivalent to £10,711) doubles the national (of ¥47,203 RMB, equivalent to £5,192) (National Bureau of Statistics of China, 2015). The urbanisation rate in Shanghai reached 90% in 2014, which is significantly higher than the national rate of 56% (National Bureau of Statistics of

China, 2015). In this context, both care provision and finance for older people is relatively advanced in Shanghai. At the forefront of marketisation in urban China, the increasingly active role of the market in home care makes Shanghai an ideal case for my thesis, where stakeholders have abundant experiences and gradually build up their views on the marketisation. The state structure of the Shanghai government and the hierarchy in the Department of Services for Older People are presented in Appendix 2 and 3, respectively.

#### 4.2.2 Semi-structured interviews

##### *Justification of the application of interviews*

The interview has been applied as the main data collection method for this thesis, which is a widely applied method in qualitative research. The interview is defined as “conversation with a purpose” (Webb and Webb, 1932, p. 130), which involves a structure, an objective, and the different roles of researcher and participants to elicit the participants’ viewpoints or perspectives on a topic (Kvale and Brinkmann, 2009; Yeo, et al., 2014). My semi-structured interviews reflect the definition made by Bryman (2012): I set questions with the flexibility for changes to the order and contents based on the responses of interviewees and my interpretations.

The merits of the interview approach have been identified in general, including the nature of in-depth responses, context information, flexibility in research design and process, first-hand data collection, interactivity, and generativity (Bryman, 2012; Yeo, et al., 2014). Through the first-hand interview process, I got access to the interviewing settings and context and process, which broadened my knowledge on the background and cast light on further analysis. At the same time, I had the opportunity and flexibility to probe viewpoints of participants through follow-up questions. For example, when some care providers emphasised that they kept paying close attention to the care quality, I investigated their motives behind it and how they had tried to improve quality.

Also, new concepts and ideas emerged from my in-depth interviews. Considering that the interview collects valuable information from experienced people (Bryman, 2012), care providers and local government officials who participated in my study had abundant working

experience and informative data in the field of care for older people in Shanghai. This thesis benefits from the interviews with these experienced participants, during which I added new follow-up questions because of unexpected responses from the interviewees. The topic guide of this study was refined during the data collection process, which is commonly applied by qualitative research based on interviews. For example, through the preliminary analysis during the data collection process, Peretti-Watel and Constance (2009) collected new themes emerging from earlier interviews to refine the topic guide for later interviews. Benefiting from the flexibility in the data collection, I was able to adapt questions, add information and modify research designs. The data collection method of semi-structured interviews offered me an effective way to gain the in-depth viewpoints of care providers and local government officials and listen to their experiences in terms of care provision, finance, and regulation.

*Sampling, sample, and recruitment of participants*

Qualitative research designs generally apply non-probability sampling (Ritchie, et al., 2014). This research applies two non-probability sampling methods that are popular in qualitative research: purposive sampling and snowballing sampling. The purposive sampling (which is also known as judgmental sampling) relies on the researcher's knowledge of a population and the potential contribution to the research objectives (Tichapondwa, 2013). The knowledge I gained from literature and pre-fieldwork supported the design for the purposive sampling of this study. Snowballing sampling, on the other hand, is usually applied when the target participants are difficult to reach. The application of the snowballing approach helped me to recruit more participants through the introduction of enrolled interviewees, especially when I had difficulties in the recruitment process when only applying the purposive sampling.

Specifically, I employed purposive sampling through three personal contacts and the snowballing sampling through recruited interviewees. Purposive sampling for this study has a key feature of "prescribed sample criteria" (Ritchie, et al., 2014), which was designed based on the categorisation of information in care policy and practice in Shanghai. As demonstrated in the previous section, the pre-fieldwork offered me the opportunity to prepare for the recruitment of potential interviewees. During it, I gained a preliminary understanding of the changing policy and research in the field of care for older people in Shanghai and established

working connections with a few managers of home care agencies who became my informants for the formal fieldwork.

During the formal fieldwork in Shanghai from February to May in 2016, I conducted semi-structured interviews with owners and managers of home care agencies and government officials working in the field of care for older people at the sub-district and community levels. I conducted two pilot interviews with one care manager and one government official in Feb 2016, so as to check whether the interview questions are clear, fluent, and understandable to participants. I also asked the interviewees in pilot studies for feedback and comments on my interviews. Only minor changes were made after the piloting on the topic guides (e.g. the questioning order, the expression of a few questions), so these two pilot interviews are also included in my dataset. Overall, 30 participants have been recruited in the research: 19 owners and managers of home care agencies, 2 frontline staff at local care centres in the community who work as care managers and care workers, 5 sub-district level government officials, and 4 community officials (see Table 4.1).

*Table 4.1 Sampling criteria*

Categories	Sub-categories	Groups	Number
Care providers	Owners and managers	Owners and senior managers who are in charge of care agencies	9
		Managers in the care service sector	7
		Managers in the marketing sector	3
	Staff in local centres	Care manager and care worker	2
Local government officials	Sub-district ( <i>jiedao</i> ) level		5
	Community ( <i>shequ</i> ) level		4

The above sampling criteria is an updated version that was modified during the fieldwork. Before conducting the formal fieldwork, I had expected to recruit 10 managers in “private care agencies” (no direct management or finance from the government) and 10 in “community agencies” (partly or fully controlled by the government) in the category of care

providers. However, I revised the preliminary sampling criteria because the boundaries between private or community care agencies were difficult to distinguish, and it would have been unrealistic to attempt to treat them separately in practice. Specifically, none of these agencies can be private when they apply for the care agency license. It is also complex to distinguish them by the control level of the government (almost all home care agencies in Shanghai rely heavily on the funding from the state). In addition, the preliminary sampling criteria allocated a big quota to the group of people who work at care service centres in each community. Yet, I found that employees at these local care centres worked more like care workers rather than care managers, which was not the target group of my study. Thus, I cut down the preliminary target number set for the group of managers in local care centres after two interviews, to get a more representative sample from the perspective of care providers instead of dispersing to care workers.

The final sampling criteria were informed by job descriptions of owners and managers of home care agencies and working levels of government officials. To compensate the cut of workers at local care centres, I then recruited more interviewees at the management level in home care agencies (19 out of 21). As shown in Table 4.1, owners and managers of care agencies have been classified into three types based on their positions and job duties in each care agency: owners or senior managers who are in charge of the whole agency; managers in the care service sector who arrange the care schedule and the management of care workers; and marketing managers who communicate with funders, co-operators, and purchasers. The owners themselves usually manage the whole business in smaller agencies with fewer employees at the management level. The care manager position is common across care agencies in varied sizes, while marketing departments have only been set up to deal with specialised issues in large for-profit care agencies.

As it is important to map the full range and diversity of participants (Lewis and Nicholls, 2014), this section describes the characteristics of the sample of 21 care providers from 13 home care agencies that were recruited in Shanghai. These care agencies vary in size and geographical coverage of care provision. As shown in Table 4.2, three of the recruited agencies only provide care services in one sub-district, seven agencies have established care

service centres over several districts in Shanghai, and three agencies provide care services in several cities of China (e.g. Shanghai, Beijing, and Chengdu). The sizes of recruited agencies vary from local care providers to large for-profit agency chains, which represent diverse types of care agencies in urban China as well as different relationships between care providers and local governments. In-depth analysis of the marketisation processes and state-market relations in which different types of agencies are involved will be discussed in Chapter 6.

*Table 4.2 Geographical coverage of recruited care agencies*

Geographical coverage	Number
Less than one district in Shanghai	3
Between one to three districts in Shanghai	6
Four or more districts in Shanghai	1
More than one city in China	3

Local government officials recruited in this study are active participants involved in the implementation of public policy and work as purchasers and regulators in the care market. Specifically, government officials were recruited from four sub-districts (*jiedao*) in Shanghai (two sub-districts in Pudong District, one in Yangpu District, and one in Huangpu District). The target group includes government officials working at the sub-district (*jiedao*) governments or the Civil Affairs Bureau (at the sub-district level) and community officials in Shanghai. These participants had direct working connections with care providers and service users. During the fieldwork, I found these government officials at the sub-district level playing complex roles in the care market, namely policy implementers, local regulators and public purchasers.

Regarding the recruitment of participants in the fieldwork, at the first stage of purposive sampling, I asked three personal contacts to introduce potential interviewees, including one academic staff member in the social work department at a university in Shanghai, one senior manager in a social work institution, and one consultant who has working connections with the care industry. However, it was difficult to recruit enough participants as the target number set in my sampling criteria. Since I did not recruit enough interviewees through the introduction of my personal contacts, I further revised the recruitment schedule by applying snowballing sampling. In the second stage, the snowballing sampling was employed to expand

the variety of means to approach participants. I asked existing participants to introduce potential interviewees in my target sampling criteria. For both sampling methods, I recruited interviewees via phone calls, texts, personal visits, and emails after getting their contact information.

A satisfactory data saturation has been achieved in terms of the sample size of interviews for this study. To identify the data saturation of my research, I refer to the principles for the data saturation in theory-based interview studies suggested by Francis, et al. (2010): setting a minimum sample size for initial analysis and deciding how many interviews need to be done until no new ideas emerge. According to my field notes and preliminary analysis, the saturation of representative participants and emerging themes occurred when 15 interviews had been conducted (8 owners and managers of care agencies, 2 care workers and managers at local care centres, 3 government officials at the sub-district level, and 2 government officials at the community level). At the later stage of my fieldwork, it was very common that different interviewees introduced the same agencies that they believed were representative ones in the care market, but those agencies had already been recruited. In this situation, I was satisfied for being able to recruit these representative care providers, but I still asked interviewees and personal contacts to introduce other agencies to increase the variety of my sample and prepare for potential comparisons between agencies.

The topic guides for the interviews (see Appendix 4 for owners and managers of care agencies, Appendix 5 for government officials) are informed by the literature review on the marketisation of care (see Chapter 2) and the Chinese context (see Chapter 3). The topics include experiences on home care policy and practice, reasons and motivations for entering the care market (only for care providers), views on the changing role of the market in home care and care for older people, relationships between different stakeholders, impacts on care providers, other participants and the care system, challenges in delivering home care services, comments on the shifting balance of the care regime, and expectations of the marketisation of home care in China.

The length of interviews ranged from 35 minutes to 90 minutes, with the majority taking around 50 minutes. All interviews were conducted at participants' offices or meeting rooms.

I conducted all interviews in Mandarin, while some interviewees spoke in Shanghainese. Shanghainese was used more frequently by government officials at the community level and staff at local care centres, while Mandarin was the mainstream for government officials at the sub-district level and senior managers of care agencies. I can understand the Shanghainese but can barely speak it, while all interviewees can understand and speak Mandarin. Thus, there was no problem with our communications in different dialects. Interviews were transcribed verbatim and checked for accuracy in Chinese while extracts for quotations have been translated into English with pseudonyms for names.

#### 4.2.3 Documentary and secondary data

Policy documents and secondary data were collected to analyse policy priorities and directions of care for older people in urban China and in Shanghai. Secondary analysis has the advantage of research breadth, complementary to in-depth interviews. As Lewis and Nicholls (2014) argued, secondary archived data could provide a different perspective to first-hand data to either support analysis or make comparisons. Analysis of policy documents and secondary data can improve the research efficiency of this study by supporting the qualitative analysis on interviews.

The secondary archived data I retrieved includes government documents in the field of care for older people, which is remarkably helpful to make inferences for a large population. Specifically, I have collected legal documents, government reports and papers in the field of care for older people, policy documents at the national level in China, which are commonly drawn by the State Council, Ministry of Civil Affairs, National Health and Family Planning Commission, and China National Working Commission on Ageing. For example, four reports from *“The Tenth Five-Year Plan”* in 2001 to *“The Thirteenth Five-Year Plan”* in 2016 were collected to analyse the historical changes of policy directions on the topic of care for older people (the First to Ninth plans did not include the social welfare or security or care for older people). Relevant laws such as *“Chinese Constitution”*, *“Marriage Law”*, and *“Law on Protection of the Rights and Interests of Older People”*, and the revisions (till March 2018) have been collected for analysis. In addition, the implementation documents and research



papers in the field of care for older people from 2005 to 2017 are included in my data for further analysis.

Except for policies and reports made by the central government, I retrieved documents regarding care for older people (from January 2000 to December 2017) issued at the municipal level in Shanghai (e.g. Shanghai municipal government, the Bureau of Civil Affairs of Shanghai). The chosen documents include policy reports and implementation or practice guidelines on all dimensions of care for older people, namely care provision, finance, and regulation. Research papers published by the Shanghai Research Centre on Ageing on their website were also included in the documentary analysis.

Even though this thesis does not aim to achieve a quantification of the marketisation level of care for older people, secondary statistical data were gathered to map the context information about ageing and care for older people. I searched statistical databases at both national and local levels, including *China Census database (2010)*, *China Statistical Yearbooks (2000, 2004, 2008, 2012 and 2015-2017)* and statistical reports about care for older people from the official websites of the National Bureau of Statistics of China and the Bureau of Statistics of Shanghai.

### *4.3 Data Analysis*

My analytic decisions were embedded in the entire process of research design, data collection, analysis and writing, which reflects Spencer et al. (2014)'s argument that the analytic journey for qualitative research is an ongoing and inherent process that infuses all aspects. The choices I made at each stage had implications for other stages and the whole research. For example, based on the literature review and information collected from the pre-fieldwork, I determined the initial sampling criteria, which consecutively shaped the structure of the interview sample and data.

Thematic analysis was applied to process the research data of semi-structured interviews and policy documents, which is an encoding qualitative information process that involves discovering, interpreting and reporting themes within data (Boyatzis, 1998). My analysis process reflected the steps of qualitative research suggested by Spencer et al. (2014),

including labelling, organising, and interpreting based on a set of themes, categories, codes, or concepts. Unlike the discourse analysis or the conversation analysis, which focus on the language or the structure of a talk, a text or an interaction to discover what the text “does”, thematic analysis is a “substantive” approach for exploring what the text “says”, which specifically focuses on the interpretation of meanings of the data (Spencer et al., 2014). Through thematic analysis, I examined the in-depth meaning of interviewees’ viewpoints and policy documents, instead of the characteristics of the language or structure of the data emphasised by discourse analysis or conversation analysis.

Regarding specific decisions for the thematic analysis, I applied the data-driven inductive approach to explore the process of home care marketisation in urban China and to refine the “marketisation of care” theory. Referring to three decisions for applying thematic analysis methods proposed by Braun and Clarke (2006): “inductive or deductive”, “semantic or interpretative”, and “realist or constructionist”, I investigated the underlying and theorised idea at the interpretative level (which go beyond the semantic description of data) with the consideration of the sociocultural and structural contexts from the constructionist perspective (rather than seeking motivation or individual psychologies). These decisions match the analysis levels of the case study approach that includes interpretational, structural, and reflective dimensions (Creswell, 2014; Tichapondwa, 2013): I analysed themes, categories and patterns of the marketisation of care at the interpretation level; examined meanings of data and themes at the structural level; and made judgements of the marketisation process at the reflective level.

Regarding practical steps of the data collection and analysis, this study reflected the classical approach proposed by Wildemuth (2009): data collection; determination of the analysis unit; making a preliminary coding scheme; sample coding; and coding all transcripts. I took a circular analytic process to refine the coding scheme and coding data. My analysis process represented two main processes of thematic analysis defined by Spencer et al. (2014): first, the “data management” stage to familiarise with data and identify themes for an initial organisation; second, the “abstraction and interpretation” stage to develop categories and to interpret data with analytic concepts and themes, which focuses on understanding, describing

and explaining the data, addressing research questions, and mapping linkages between different themes and data. More specifically, my analytic journey matches five steps proposed by Spencer et al. (2014): 1) familiarising data to overview what participants said and identifying topics and subjects of interest; 2) generating an initial thematic framework; 3) indexing and sorting the data into the same topics under the thematic framework; 4) refining initial thematic frameworks; and 5) data summary and display.

After sorting the raw data with the initial coding scheme, I repeatedly read and thematically coded the verbatim transcripts in Chinese, through which QSR NVivo was used to facilitate analysis. The unit of coding was quasi-paragraph for both interviews and policy documents. I coded themes, categories, and sub-categories transparently, coherently, and consistently through the process. The codebook of interview transcripts and policy documents shows how the themes emerged and compared views of each group and different sources for similarities and differences. After the emerging themes were identified and analysed in-depth, I translated extracts from respondents' narratives to English to illustrate each theme, using anonymised quotations.

#### *4.4 Practical and Ethical Issues*

This thesis complies with the research ethics guideline of the School for Policy Studies, University of Bristol (see Appendix 9). All participants have provided written Informed Consent to Participation (see Appendix 6). The Participant Information Sheet (PIS) (see Appendix 7) introduces the study and assures confidentiality to the interviewees. Each participant was asked for written informed consent and permission for digital recording before the interview. They must fully understand the research process and attend the interview voluntarily. Participants were free to terminate the interview if uncomfortable during the interview. A small box of chocolates was provided as a gift for their assistance. Participants were offered a two-week "cooling off" period, which means the data cannot be withdrawn after the cooling off period to ensure the scheduled research progress. Subsequently, there was no withdrawal from the data set.

I had anticipated the risks to the participants before the fieldwork to try to minimise the potential unwanted effects. For interviewees who may worry about their responses known to other stakeholders, I informed them that their responses would be strictly confidential, protected from any other stakeholders in their business (e.g. policymakers, local government officials, other agencies). Considering the recruitment process, my personal contacts had equal working connections with potential participants, which would not cast unexpected pressure for them to participate. Yet, sometimes there was unavoidable hierarchy pressure between interviewees when I applied the snowballing sampling. For example, a government official in a subordinate position would normally agree to participate in my study if his/her superiors suggested.

The confidentiality is also stated clearly in the PIS and verbally explained again at the beginning of each interview. First, the recruitment letter and PIS state clearly that it is their voluntary decision on whether to participate in the research or not, so the participant would not feel obliged to take part in the research. Second, to minimise potential risks and reassure the participants, I verbally explained the voluntary participation principle and confidentiality before each interview. I also found changes in the attitudes of some interviewees during the interviews: from following the introduction from senior managers to enjoying the conversation to share their viewpoints and experiences in the field.

Concerning the safety of participants and the researcher, all interviews were conducted during office hours in the workplace, such as interviewees' offices and meeting rooms. I informed another person (family or friend) about the date and location of each interview. All participants were aware of this arrangement. I registered a mobile number in Shanghai, which was used exclusively for this research to contact participants. During my fieldwork period, I also kept a monthly check with my supervisors to report the progress of the data collection and my health and safety situations.

The interviews were recorded with a digital voice recorder with permission given by participants. The recordings were downloaded into a password-protected computer. All identifying features were removed from the transcription to keep anonymisation. Pseudonyms for names of participants and care agencies were cautiously coded. Local

government officials were happy for me to use their authority locations in this thesis or further publications, yet, I only applied rough information without the specific authority names in my analysis (e.g. locating to the real district level but giving pseudonyms for sub-district names). The interview transcripts are used anonymously for my thesis and further publications arising from this research. Participants were informed that all the data will be stored for 10 years on an appropriate storage facility complying with University of Bristol Data Storage Policy.

#### *4.5 Limitations*

Interview is commonly criticised for the limitations of high subjectivity and low generalisation. It was difficult to achieve neutrality during this study, which involves my personal interpretations, reflections on research and interactions with participants. Even though 21 interviews with owners and managers of care agencies have covered a representative group of home care providers in Shanghai, the lack of quantitative or statistical data on the population challenges the generalisation of this thesis. Inevitably, practicality reminded me to be realistic on the research design. Even though the subjectivity biases could be reduced with a larger sample size, this study cannot include too many participants with the consideration of limited time and resources. Instead, I managed to improve the diversity and representativeness of interviewees during the data collection process, as well as made cautious generalisations in the analysis stage.

In addition, care providers and local governments were chosen as the target groups of this study based on the research objective of drawing an exploratory picture of the marketisation process. The viewpoints of other key stakeholders in the care market are not included in my fieldwork, such as policymakers, older people and their families, care workers. As a PhD thesis conducted by one researcher, the time and resources were insufficient for a large-scale study. Moreover, the priorities of this thesis focus on exploring the process of marketisation, the changes of policy and practice, the outcomes and prospects of marketisation in urban China from a macro perspective, on which care providers and local governments are more informative than other groups. Evidence related to the quality of services or the effects of marketisation on these are not my primary research objectives; instead, I was seeking the

views and experiences of those who were involved at this specific point in the marketisation process.

### *Conclusion*

This chapter has explained the methodological approach and research methods employed in my study. To recap, the qualitative approach is applied based on the exploratory research question of this thesis. In the case field of Shanghai, owners and managers of home care agencies and local government officials working in the field of care for older people were recruited for semi-structured interviews. Thematic analysis was applied to process the interview transcripts and policy documents. This leads to the findings being presented in a thematic format: the status and understandings of home care, processes of marketisation and quasi-market models, and outcomes of the marketisation will be analysed with empirical and documentary data in Chapters 5, 6 and 7, respectively.

## Chapter 5 Home Care at the Central Position for the Marketisation of Care in China

---

### *Introduction*

In the context that the traditional family care faces challenges (see Chapter 3), documentary and fieldwork data of this thesis show the central position of home care in the developing care system for older people in China. Family-centred cultural norms exert influence on policy intentions and the choices of older people and their families in care arrangements, while in turn get counter-influenced by policy and practice. This chapter explores why home care is chosen as the main care arrangement approach by the state and individuals and how cultural values shape the marketisation of care in urban China. The first section argues that cultural norms of “filial piety” are constantly embedded in the care system in China, whereby the family-based intergenerational bonds remain an important support source for older people. It also demonstrates increasing stress for adult children in the dimensions of care provision and financial support, followed by the analysis on changing attitudes towards saving and consumption in the context of socio-economic changes.

Section 5.2 discusses influential factors in the decision-making process of care arrangements for older people in practice, such as economic concerns for families and the state. As illustrated in Chapter 3, there is no consensus on definitions of “home care” and “community care” in care policy and practice in China. Based on the fieldwork and documentary data, this section compares contested definitions for family care, home care, community care and the structure of the care system, and then discusses the relationship between different care approaches. How the market supports families in home care practice is analysed as well. Section 5.3 illustrates the importance of the community in home care practice, including volunteer support to older people and community quasi-government function branches.

### *5.1 Persistent Cultural Values of “Filial Piety” & Social Changes*

#### *5.1.1 Moral and legal obligations of “filial piety”*

The family sector retains a supreme role in care provision and financing for older people in China (see Chapter 3). According to documentary and empirical data, familial support to older

people is morally and legally encouraged in China. In general, interviewees agreed that the “filial piety” norms are persistently embedded in Chinese families. As a moral obligation in the Confucian family, cultural norms of “filial piety” rooted in China involuntarily allocate the care responsibility to families. During my fieldwork, there was a consensus among interviewees: family members (spouse and children) are the first source of support for older people in the dimensions of care provision and finance.

“If children do not take the caring obligation when they are able to, their behaviours are not acceptable in Oriental Culture. In oriental countries influenced by the Confucian culture, including (China), Japan and South Korea, when we judge people, we attach importance to the impression on how they provide familial support.”

Hao, government official at the sub-district level

“If the children do not show filial piety to their parents when they are old, this family is an ‘unhealthy’ unit.”

Le, executive of a care agency

“When a person is in need of care, his family is the main supporter of him. He should try to seek help from family members as the first step. Unless the duty is beyond the ability of his family, the state has the responsibility to provide help to this person...Otherwise, considering the huge population in China, the state cannot afford the care for all older people.”

Zhan, government official at the sub-district level

As discussed in Chapter 3, since socio-economic reforms in the 1980s, it has been more difficult for adult children to provide direct care to older people, while increasing financial support has been applied to replace the reduction in traditional family care provision. Participants in my fieldwork suggested that adult children should provide financial support to older people when they are not available for personal and practical care. They also suggested that the level of financial support is based on the economic capacity of both older people and their adult children.

“Most children are no longer living together with their parents, some are even abroad. Most children have jobs. It is impossible for all adult children to provide direct care for their parents. But if their parents need money, it is what the children can provide.”

Li, government official at the sub-district level

In addition to moral obligation, intergenerational support from adult children to older people has been legislated in China. The Chinese Constitution (current version adopted in 1982, with



revisions in 1988, 1993, 1999, 2004 and 2018) claims that adult children have an obligation to support and assist their parents in two dimensions: first, providing essential living goods and monetary help in the financial dimension; and second, emotionally and practically respecting, caring, and looking after older people in the care provision dimension. The “Marriage Law of China” (1980) specifies that if older people are incapable of working or have difficulties in daily life, adult children (regardless of gender and marital status) have the obligation to provide alimony to their parents. The Marriage Law also stipulates that if the children are dead, adult grandchildren are obliged to take the care responsibility for their grandparents (if applicable). Home care is prescribed as the basis for the care system for older people in “Law on Protection of the Rights and Interests of Older People” (2012), which also emphasises that family members ought to respect, care for, and look after older people. This law encourages family members to live together with or close to older people, while requiring those living at a distance to visit their parents frequently. Discrimination, insults, abuse, or neglect against older people are stated as illegal by the “Law on Protection of the Rights and Interests of Older People”.

Even though filial piety is a moral and legalised responsibility for Chinese people, some interviewees in my study criticised that these legal regulations are barely applied in practice or in court. First, cases involving discrimination, insult, abuse, or neglect of older people require individual prosecution in China, which need to be proposed by older people themselves or their family members rather than authorities. However, older people are generally unwilling to apply legal actions, influenced by social-cultural norms on avoidance of litigation (Peng and Zhou, 2014; Chan, 2017), especially in cases that involve family issues. Seeking external help (such as lawsuits) on family conflicts is widely believed as a humiliation on all family members, including victims themselves. For example, if older people seek legal help when being abandoned, they might feel guilty themselves or be insulted by others for failing in educating their children and deliberately making the relationship worse between family members with lawsuits. Influenced by this “avoidance to the litigation” idea, participants in my study suggested that laws rarely get applied when older people are exposed to abominable unfilial behaviours (e.g. adult children who are capable of providing basic maintenance but do not take the responsibility).

Second, the effectiveness of these legal regulations is questioned in practice, because it is difficult to achieve intended results from the lawsuit, even when older people decide to sue their irresponsible children. Based on their working experiences, the government officials participating in my interviews suggested that the execution of judgements against adult children usually are ineffective in older people's lives. Considering the reason behind the low efficiency of court cases on the care arrangement issues, Chinese laws in terms of the protection of older people (including "*Chinese Constitution*", "*Marriage Law*", and "*Law on Protection of the Rights and Interests of Older People*") are designed to encourage moral obligations rather than setting detailed penalties to punish those who would break them. It was a consensus among interviewed government officials that older people have difficulties in gaining alimony or care from adult children as the judgement requested. In this context, interviewees criticised the practicality of legal regulations and suggested policymakers take more considerations on behalf of vulnerable older people. For example, Zhan, a government official at the sub-district level, argued that "*I think the government should make legally binding rules, or take actions to maintain the healthy relationships within families.*"

#### 5.1.2 Increasing pressure on adult children

Even though Chinese people value the "family" and "filial piety" in terms of care for older people, families cannot meet the dramatically increasing care needs under the demographic and socio-economic changes (see Chapter 3). From the perspective of family provision, it has been getting increasingly difficult for adult children to take caring duty in recent decades. According to the working experience of government officials and care providers in my fieldwork, various objective barriers were identified for adult children in taking the care duty for their parents, such as low income, small house, and heavy workload. Many participants argued that it is unlikely that Chinese adult children would be unwilling to take the caring responsibility with considerations of moral obligation and peer pressure based on persistent "filial piety" cultural norms. On the contrary, the external "burden" on adult children was recognised, especially in the dimension of care provision for older people.

"For plenty of families, 'their spirit is willing, but the flesh is weak' (*xin youyu er li buzhu*). For service users in our agency, their families mainly provide mental and financial support."

Liang, deputy of a care agency

“Lots of people at my age need to work. If you are not living together with parents, you will only be available on weekends to visit and take care of them. But for the majority of older people, daily practical care is their basic needs, such as helping them do the grocery shopping and see doctors. These care needs cannot be dealt with on weekends or within annual leave allowance; our holidays are very short.”

Zhou, executive of a care agency

Intergenerational support between younger and older generations is significantly high in both dimensions of financial support and care provision in China. The proportion of care provision and financial support is influenced by living status (e.g. where adult children live and work, where older people live, the household structure) and economic background of families (incomes of older people and their children). For the majority of adult children, it is no longer realistic or feasible for them to provide full-time practical care for their parents. Financial support is an alternative way to fulfil their filial piety, but it is not equally achievable for adult children based on different economic backgrounds.

“The amount of financial support to parents depends on the economic situation of each family. In some families, older people have high pensions or other income, so they do not need money from children. If older people do not have enough money, their children will take care of their parents. Chinese families will not leave older people alone. Only the level of their support is different, depending on their own abilities.”

Xin, deputy of a care agency

Owners and managers in care agencies in my fieldwork shared cases from their working experience to illustrate how the economic background of families influences the care arrangement for older people. For example, care agency “Happy South” provides both home care and community care, in which the majority of service users have pensions in the range of ¥2,000 to 3,000 RMB (£220 to £330) per month. The deputy manager of “Happy South” argued that service fees on day care (at home or at day care centres) is above ¥3,000 RMB per month for bed-bound older people. When service fees and daily expenses of older people exceed their pensions and other income, extra payments are usually covered by their family members. According to the deputy manager, this agency only got one client whose family (one unmarried daughter) cannot afford the excess part above his pension. In this case, the daughter tried to provide care herself for a longer time every day so as to purchase fewer hours of services from care workers, as well as apply for some hardship fund from the state.

As the above case shows, families in poor economic situation experience challenges during the care arrangement for older people. What is more, the interviewees suggested that some families were too poor to purchase in the care market (who cannot afford to be their clients). In these cases, adult children have to take the full responsibility to care for their parents (provision and finance) or leave them suffering alone as unworthy children who violate filial piety. The interview data demonstrate that unless in very rich families, the “sandwich generation” who simultaneously provide care to their parents and children (Grundy and Henretta, 2006) find it extremely stressful under the caring responsibility, which is in accordance with Chinese academic research (e.g. Zhang and Goza, 2006; Guo, et al., 2015). Even if the affordability of care services of older people and their adult children has increased since the economic reforms in urban China, it is an agreed view that the “sandwich generation” generally has difficulties in providing and purchasing care for their parents.

#### 5.1.3 Older people’s attitudes towards saving and consumption

There was a popular view among my interviewees that the current old-old cohort (aged 80 or over) is generally thrifty on daily expenditure, especially in purchasing care services. The interviewees from both groups of government officials and care providers argued that the old-old cohort tried to cope with daily life without external help (who are indeed in need due to their health and physical status), even if they have a large fortune or house estates or their children are willing and able to purchase care services for them. It was proposed that the willingness to purchase services or allowing their children to purchase services for them is generally low among older people.

“Older residents do have needs for professional care. Some of them are not able to walk out of the house. However, they have plenty of considerations when making decisions to move to care homes or to employ care workers. Their living ideas focus on saving and thrift.”

Zhou, executive of a care agency

“Current old-old cohort is not willing to accept marketised services. They do not want to spend money. Thus, we (agencies) still focus on providing low-price or state-paid services.”

Hua, care manager

Considering the rationale behind the low willingness of older people to purchase care services, I identify two main reasons based on the fieldwork data, namely cultural preferences on savings than consumption, and cohort thrifty experiences in earlier life. First, preferences on savings are a supposed cultural characteristic in China, especially for older people. The attitudes towards consumption and saving have impacts on their decision-making process for care arrangement. Referring to the pragmatic decisions of the old-old cohort, the interview data show that the preference on saving money (to themselves and younger generations) is an important reason for why booming care needs in China do not appear as purchasing power in the care market.

“Considering the consumption attitudes of older people in China, they have money, but they will not spend it. Instead, they have saved for thousands, even millions for their children. They will not sell their houses (even if they have spare ones). They keep houses for their children... We (governments) are trying to promote the care market but few people would like to purchase services.”

Hao, government official at the sub-district level

“During the communication with older people, we found that it is very difficult for them to make the decision on purchasing marketised or socialised care services. Why? Because the purchasing power, purchasing ideas, and acceptability levels of the care market are variable among older people. Willingness and acceptability level (of purchasing in the market) are generally low in this age group.”

Xie, marketing manager in a care agency

“Some older people have pensions around ¥4,000 to ¥5,000 RMB (£ 440 to £550), which is enough for a good life as well as purchase care services because they have their own house. However, they do not want to spend for themselves. It is common. They treat it as traditional norms.”

Chao, deputy of a care agency

Purchasing attitudes of older people are also different towards different types of products. The interviewees suggested that willingness on the purchase of services was generally much lower than the purchase of material objects. For example, Hua, a care manager, argued that equipment companies (e.g. wheelchair, mobile phones for older people) had started to gain profits in recent years with increasing purchases, while care services are not priorities in older people's wish list because the service is an “invisible” product that cannot leave a material object to them. She compared this idea to older people's attitudes towards paying bills to doctors and purchasing medications: “it is the same logic why older people like to pay for medications but not for doctors' services”.

Second, thrifty time experienced by the old-old cohort have impacts on their behaviours and attitudes in their later life. Participants in my fieldwork explained that the old-old cohort in China experienced wars and lived in poor conditions in their youth, which had impacts on their way of life. For example, Le, an executive of a care agency, suggested that the lack of willingness on the purchase was because of older people's persistent ideas to live in thrift, which has acted as their life attitudes since poor times in youth. Ideas of frugality are rooted in their experiences and difficult to change in their later life, no matter whether their current economic situation has improved or not.

“The idea towards purchasing is not open. Older people who are in their 70s or 80s, lived in a thrifty time when they were in their most energetic time: historical tough time for China, the ‘Cultural Revolution’, before ‘Reform and Opening-Up’, their experiences in poor situations strongly influence their attitudes and viewpoints.”

Lei, community official

In general, public attitudes towards purchasing care services are changing, especially for younger cohorts. The interviewees suggested that the consumption ideas of younger generations are different to older people. As argued by most interviewees, younger cohorts show more willingness for consumption than older people. Services (in the care sector and other fields) and basic entertainments were essential factors for life quality for younger people. Compared to ideas of the older generation who would like to save money and houses for their offspring, the younger generation proposed to give priorities to their own life quality.

“For the younger generation, maybe from my cohort (born in the 1970s), we care more about life quality. We would like to sell big houses and move to small houses in later life if we need money for care or other basic needs. But, the current older group treats the accumulation of wealth (money, house) more important than life quality.”

Hao, government official at the sub-district level

With considerations on the stronger purchasing power and more positive attitudes of younger cohorts, interviewees identified the potential development of the care market with wealthier generations getting older (those born in the 1950s and the 1960s). For example, the interviewees proposed that the wealth aggregated cohort in China is urban residents. “Chinese Aunties”, referring to a group of middle-aged women who act as strong purchasers in the market (e.g. gold, house estates, stock), have gained attention from market suppliers.

“Those who have gained wealth since the ‘Reform and Opening-Up’ have discourse power and purchasing power in the market. Care providers have also noticed this, and they are looking forward to the potential development of the care market when ‘Chinese Aunties’ get older to purchase care services.”

Zhan, government official at the sub-district level

## 5.2 *Home Care as a Mainstream Choice for Care Arrangements*

The traditional family care system can no longer last in China due to socio-economic changes from the 1980s (see Chapter 3). In this context, home care, which combines familial factors and the involvement of the care market, becomes a popular choice for urban residents to replace the traditional family care and at the same time to comply with cultural norms on filial piety. Participants in my fieldwork held a consensus that Chinese people have preferences for home care rather than other approaches. When family members have difficulties in providing care, older people and their families (as a joint decision maker) still want to keep them at home as long as possible.

“Home care matches the needs of most Chinese people.”

Lu, care manager

### 5.2.1 Preferences on home care & lack of shared understanding of terms

Considering the location for care provision, receiving care in older people’s own homes matches preferences of the state and older people and their families. Regarding saving public investment, the state aims to purchase care services as cheaply as possible. From both ideological and pragmatic perspectives, it was a widely accepted view in my fieldwork that older people and their families prefer to get access to care at home to reduce expenses and generally give the chance for older people to have more time with families. Referring to Shanghai Municipal government (2014), Shanghai Investigation Organisation of National Bureau of Statistics conducted a survey with 2248 older people aged 60 to 79 in 2013, showing that 67.3% of participants prefer “traditional family care”, 21.2% prefer “community home care”, 11.1% prefer “residential care”. From this survey, older people’s willingness to stay at home for care is evidently strong. However, the definitions for each option in this survey are not elaborated, especially for “community home care”.

The interview data from my fieldwork show a complex picture for preferences of older people and other stakeholders on care arrangement methods. A widespread understanding of the hierarchy of care arrangement decisions mixes up considerations on two factors of locations and providers: older people living independently, family members providing care (exclusively from spouse; mixed caregivers of spouse and adult children; exclusively from children), mixed care providers of family members and care workers, exclusively caring by care workers at home, and moving into care homes. The interview data suggest this as a preferred order by most Chinese older people and their families in general, rather than a realistic flow for every single case. The economic situation of older people and their families, individual health status, and other issues influence their choices in practice. For example, some families cannot afford the employment of care workers for 24 hours, or some older people get to the care homes at an earlier stage.

“For most older people living in care homes, their families met extreme difficulties in providing care at home. The children have no other choices... For example, there is an old lady who is bed-bound for more than five years. Even though we (this home care agency) provided some home care services during that period, several family members got exhausted because of long-time care provision. Even though they had purchased external care services, her family members were too tired to carry on the care duty, which cast negative impacts on their own lives. Finally, the children sent her to a care home earlier this year.”

Le, executive of a care agency

The Chinese government also takes into account cultural norms and ideas of older people during decision-making. In the context of the increasing care deficit in China, the value of home care has been emphasised by the state. Concerning filial piety as important cultural norms to Chinese people, some local government officials argued that they prefer the option to expand home care rather than invest in residential care at the local level.

“When we design projects (regarding care for older people), we consciously make ‘breathing’ services to help family caregivers. Activities organised by the state are guided in this direction. Most policies are relevant to people’s ideas.”

Jiao, government official at the sub-district level

“From the perspective of the Chinese tradition, people would not like to choose residential care. Older people cannot get used to the living styles in care homes. Also, the availability of care homes is an important obstacle. It is totally not enough, not enough in the city centre, while limited in suburban areas. This is a big problem for us.”

Hao, government official at the sub-district level



Some large for-profit agencies possess both home care institutions and residential care homes. Among the large for-profit care agencies recruited in my study, some started the business by providing home care, while others started with residential care. Those who launched a home care agency at the first stage explained that it is still difficult for home care agencies to gain profits in the market, so they set up residential branches to share the basic costs, to attract more service users, and to meet more criteria requirements of financial support provided by the state (which is different for home care and residential agencies). Interviewees from those agencies that started as care homes argued that the main reason to join in the home care market was noticeable potential care needs which might bring the opportunity of further expansions and profits.

“As a care agency, we also wish to support moral obligations (*renlun*) that families ought to take care of older people, which is suitable to Chinese traditional ideas. It meets the willingness of older people. Chinese older people like staying at home. So, the duty of our agency is to advocate and promote families to arrange better care of older people.”

Yang, owner of a care agency

Meanwhile, it is an easier way for the state to establish a reliable care system based on home care for older people. Government officials who participated in my fieldwork suggested advantages of home care in saving resources for the state and respecting the willingness of older people. During the decision-making process at the local government level, regional characteristics were proposed as influential determinants. Hao, a government official at the management level in a sub-district defined as an “old urban area”, suggested the characteristics of this jurisdiction: developed economy, abundant public budget, the large number of older people in need of care service, insufficient care homes and public land for building new care homes.

“With the same size of space, home care agency can cover care needs of at least double the amount of older people than residential care. I would surely allocate the estate for home care (agencies). Why do we need the home-community support plan? If an older person joins in the home care agency, family caregivers can have a short break to improve their own life quality. Also, older people need to take part in group activities as well as keep a close relationship with their families. (After taking services), older people must be able to get back to their home.”

Hao, government official at the sub-district level

Even though home care is suggested as the more preferred care arrangement approach for Chinese people in general, the acceptance level of residential care has increased in urban China. The criticism on residential care as unconformity against the traditional cultural norms of filial piety still exist in Chinese society, but the widespread stigmatised label is gradually fading away, especially in large cities like Shanghai. Yet, residential care is sometimes not easily accessible for older people.

Interviewees in my fieldwork proposed two main reasons for the difficulties in getting access to care homes; first, the availability of residential institutions cannot match the large older population in China; second, some older people (and their families) cannot afford residential fees. Due to the situation that limited public support cannot match the considerable care needs in China, older people have to purchase care services in the market with their own incomes or with financial support from their families. Consequently, preferences on home care and objective constraints to get access to residential care jointly lead to the situation that home care is an unreplaceable choice for older people.

“Home care is the most popular choice for Chinese people, but not the first choice for all. Some families wish to get their older members accommodated in a care home, but they cannot afford it; or sometimes, the waiting lists for care homes are too long, they have no choice but stay at home to wait.”

Feng, community official

### 5.2.2 Contested definitions of home care and the structure of care system

Purchasing home care services in the market is designed to support the traditional family care. However, definitions of “home care” and other care arrangements have no consensus in China in policy and practice. As discussed in Chapter 3, existing definitions by government documents and different researchers are either not clear or contested between each other, especially for home care and community care. Referring to the interview data, care providers and local government officials who are working in the care field have no consensus about the definitions for “home care”, “community care”, “community-based home care” and the structure of the care system. Based on the empirical and documentary data, this section compares definitions for different care approaches and the structure of the care system in Table 5.1. Because the interviewees and policy documents generally have a consensus on the

definition of residential care (implying older people living in care homes for services), residential care is not included in this table.

Specifically, I divide interpretations on the structure of the care system into three categories, reflecting different combinations of home care, community care, and residential care. The first row in Table 5.1 shows definitions applied in government documents. As discussed in Chapter 3, the Chinese government suggests that home care is the foundation of the Chinese care system. The structure of the care system of home care, community care, and residential care is expressed as “9073” in Shanghai (90% home care, 7% community care, and 3% residential care) in government documents. Unfortunately, the state does not give clear definitions for each type.

*Table 5.1 Different understandings of home care and the “9073” care system*

<b>Structure of care system</b>	<b>Sources</b>	<b>Family care</b>	<b>Home care</b>	<b>Community care</b>
<b>90% home care,</b> <b>7% community care,</b> <b>3% residential care</b>	Government documents (Ministry of Civil Affairs in China, State Council)	Care exclusively provided by family members	Centred on families, relied on the community, supported by external services; Providing care to older people who are living at home; Different from traditional family care.	N/A
	Fang, marketing manager	N/A	Family support; Living at home; Relying on the community for external care services.	N/A
<b>90% home care,</b> <b>No difference between home care and community care</b>	Lu, care manager	Living with children or relatives; Care provided by family members.	Centred on families, relying on professional care providers in the community (including day care centre, employing care workers or purchasing services at home.)	
	Zheng, marketing manager	The mutually beneficial balance between generations; Intergenerational “pension” system within families, involving payment, accumulation, appreciation, and claim back.	The same definition of home care as policy documents; Providing socialised services to older people who are living at home; Including care provided in older people’s homes and community care centres	

Structure of care system	Sources	Family care	Home care	Community care
<b>90% family care,</b> <b>7% home and community care,</b> <b>3% residential care</b>	Hao, sub-district government official	Living at home; no support from the state; care purchased by individuals and their families.	Care provided in older people's homes with subsidies from the state; No differences between home care and community care.	
	Qing, Owner of a care agency	Older people live in their own homes; Families take care of older people; Privately purchasing services from the market.	Living at home; Receiving free state-paid home care services; Older people and their families purchase extra care services from local authorities selected as "community-home care agencies".	

Most interviewees recruited in my study did not agree with the official "9073" definition. The second category demonstrated in Table 5.1 agrees on the proportion of home care in the care system (90%) and the definition of family care indicated in government documents. However, in contrast to the definition of two different care approaches in government documents, this group of interviewees treated home care and community care as the same type to represent 90% in the care system. They argued that there was no persuasive evidence for how and why the state set up the proportion for community care (7%), so they believed the combination number was no more than a rough idea that cannot reflect the practice.

Interviewees categorised in the second group argued that it was difficult to differentiate home care and community care, because the locations and the purchasers of these two types of care are complex and mixed. Instead, they defined a concept as "home-community care", which combines familial support with external care services for older people who live at home, including home-based care and services provided in the community (e.g. at a day care centre). Some interviewees in the second category suggested that a crucial difference between home care and community care is who pays for the services. Wei, a government official at the sub-district level, argued that even though home care and community care are similar in performance, the difference may focus on whether service users have access to

subsidies from the state: home care is for specific groups who are financially supported by themselves or families, while community care is for those who are supported by the state. Yet, this point of difference was suggested to be only applicable to understand care practice instead of the “9073” combination, because the state-paid home care services (defined as community care by a few interviewees in this group) was far lower than 7% of the older population as proposed in the official definition (i.e. Category 1).

“I don’t think the state has done a measurement or calculation for the ‘9073’. Instead, it is more like a conceptual idea.”

Zhan, government official at the sub-district level

“Home care is centred on families, relying on professional service providers in the community. It combines families and the community into the care provision for older people.”

Sun, care manager

The third category illustrates the “9073” slogan as 90% family care, 7% home and community care, and 3% residential care. It is surprisingly different from the statement of the state. Referring to the interpretations of advocates of this category, the key point between family care and home community care is whether the state allocates subsidies to older people, which was suggested as a possible difference between home care and community care by some arguments in the second category as well. The third category suggested that family care is still the mainstream care arrangement for older people in China, which is personally, emotionally and financially provided by families without any support from the state. Chapter 6 will illustrate strategies of the marketisation of care applied by the Chinese government, which includes the way subsidies and other support from the state are allocated. Unlike other categories, the direct purchases of care services by older people and their families with their private funding is defined as family care by this group.

“Regarding 90% as home care, no matter for the current or future situations, 90% is self-caring rather than care provided by care workers in older people’s homes. It is even impossible to get that amount of care workers.”

Zhan, government official at the sub-district level

The definitions applied in this thesis (see Chapter 3) are differentiated based on the locations where older people receive services and who provides care. Specifically, I define “home care”

as care provided in older people's homes by care workers or a mix of care workers and family members, including mixed types of personal care, practical care, and emotional support. Based on the interpretations of local government officials and care providers and observations in the fieldwork, my definitions for each type of care can exclusively differentiate between each other. Yet, the funding providers (who pay for care services) are not reflected in my definitions, which will be discussed as marketisation processes in greater detail in Chapter 6.

"Community care" in this thesis includes care services provided in the community, which differentiates it from residential care and home care by location. Considering care provision for older residents, many communities (*shequ*) have set up a few residential care homes and non-residential care centres. As investigated by Ochiai (2009), 32.9% of *shequ* had care institutions for older people. According to the data published by the Ministry of Civil Affairs of China (2017a), there were overall 140,000 care institutions or facilities in 2016, among which only 29,000 were care homes, 35,000 community care service centres and facilities, and 76,000 communal care facilities in rural communities (e.g. activity centres for older people, day-care centres). The coverage of community care institutions has significantly expanded in recent years, which provides choices for residents to easily get access to care in the close neighbourhood, especially for short-term residential care and day care.

Considering the decision-making of care arrangement methods, a few influential factors are identified based on interviewees' arguments: economic background of families, health situation of older people, living length of older residents in one community. First, economic concerns significantly influence the choice-making for older people and their families (see Section 5.1.2). Second, the health situation of older people is highly related to the level of care needs. For example, Mai, the owner of a care agency, argued that home care is suitable for older people who are generally healthy or those with minor health problems but still capable of looking after themselves, while 24-hour care services provided in residential institutions or community care centres are chosen by older people who are incapable of looking after themselves. Third, the length of residence in one community was suggested as a crucial factor when older people and their families make choices between home care and

community care. Lei, a community official, argued that home care is more popular for new residents who are not familiar with the surrounding environment, while community care is a common option for people who have lived in a community for a long time and know the community and neighbours well.

### 5.2.3 Relationships between care arrangement approaches

Interviewees in my study argued that different care approaches (i.e. home care, community care, and residential care) do not contradict each other; instead, they support each other in establishing a more stable care system. There was a consensus on the importance of increasing the public investment in the care field. Several interviewees proposed differences between the “saying” and “doing” of the Chinese government in the field of care for older people. They complained that the state only encourages home care in paperwork without allocating corresponding financial resources to the sector.

“Even though the state suggests that we need to promote home care, political leaders have not talked about how. Motivated by policies issued by the central government, local governments started to explore how to carry out home care. Agencies in the market take part in the field and sometimes undertake care projects with funding from the state. Then the state cooperates with the market in home care practice.”

Yi, owner of a care agency

The interview data and action plans of the central government and local governments indicate that public funding is geared towards residential and community care rather than the home care sector. The evaluation criteria made by superior governments (e.g. central government, municipal governments) emphasise the number of facilities and the capacity of community and residential institutions in each local authority. In terms of home care services for older people, the state only tries to cover those “most vulnerable groups” of older people (gradually expanding from “three-no older people” who have no capacity to work, no income, and no informal support, to include older people relying on the basic living allowance and aged 90 years or older, etc.) with a limited amount of state-paid services (20 or 25 hours per month). The quote below shows the target group and the amount of state-paid home care services in Shanghai.



## Chapter 5

### Home Care at the Central Position for the Marketisation of Care in China

“Older people aged 90 or over have access to free home care paid by the state. The number of free services for them is no more than 25 hours per month. If the qualified older people move to a care home, they can apply for the alternative cash of home care services (not equivalent to the market price) to pay for fees in care homes...about ¥200 to 300 RMB (£22-33) per month.”

Ying, community official

Even though policies suggest that home care would represent 90% of the care system, interviewees argued that the state has not given priority to the development of home care in practice. The interview data demonstrate that there are two reasons in relation to the dilemma between the high importance of home care in policy rhetoric and low financial support in practice. First, one explanation focuses on the motive of the government: it is easier to invest in constructing facilities of community care and residential care and to evaluate the quantitative outcomes than in home care services.

Second, the Chinese government currently focuses on basic protection for the poorest group with no subsidies to the public in purchasing services. Several government officials suggested that investing in care homes helps to improve care provision to those older people who are in desperate need of care outside of their families. For example, their health situation calls for external help or no informal care available. Embracing the idea to help the most vulnerable group, advocates argued that investments in residential care are more efficient and more urgent for the current stage for China. Several hypotheses are embedded in this viewpoint: home care involves more familial support than residential care; older people would not move to care homes unless they cannot get enough familial support (e.g. no adult children, severe health problems); older people who need residential care have less support from their families; older people who move to care homes are more vulnerable than those who seek home care.

“There are debates about the policy direction of ‘protection to the basic’ or ‘pay incentive money to a bigger market’. The current policy is ‘protect the poorest and most vulnerable older people’.”

Hao, government official at the sub-district level

Referring to the debate within the government, some government officials participating in my study supported the “protection for basic”, based on the concerns of the limited budget of the state, the importance of the basic protection, and the anticipation that the public can

be encouraged to enter the care market through self-funding. Meanwhile, other interviewees were advocates for making public policy for all older people, which means to expand the coverage of state-paid services. They criticised that the current threshold line for state-paid services is too strict. Older people who are beyond this threshold level also encounter financial obstacles when purchasing services on their own income. For example, Hao (a government official at the sub-district level) argued that older people whose monthly income falls between ¥3,000 and 4,000 RMB (£330 to £440) were the public group in need of financial support for care services (threshold level in 2016 was ¥2964 RMB (£326.04) in Shanghai). The debates on the priorities of the state allowance will be discussed in Chapter 8 in greater detail.

“The government should consider the public, instead of extremely rich or extremely poor groups. The majority of older people are in the middle. The development of the care market and fulfilment of care needs of older people would get marvellously improved if the government gives more attention to the needs of the public.”

Zhan, government official at the sub-district level

“I hope the coverage of support policy can be expanded, to help more people to get access to our services.”

Lu, care manager

“A massive group of older people has income a bit higher than this threshold (lower than ¥2964 RMB, equivalent to £326.04) to qualify to get free home care services for 20 hours per month, but they still cannot afford services in the market based on their own income.”

Zhou, executive of a care agency

Interviewees suggested it is unreasonable for the state to make an “either-or” choice between different care arrangements (e.g. residential care or home care). On one hand, welfare for older people is generally at a low-level in China. It was a widespread argument that public investments in the care field need to be increased in general, regardless of the care approaches or locations to receive care. On the other hand, a few interviewees argued that it would be better if the evaluation criteria changes from focusing on the number of residential beds to include the number of older people who are covered by state-paid care services. It is important to involve the coverage of the target group and the quality of care services for the assessment of public investments, rather than exclusively concentrating on the number of care facilities.

“There are so many care homes being constructed with large monetary costs. Why not allocate some of the funding to home care? For example, one residential building might cost ¥100 million RMB (£11 million); its operation fees might be 1 million per year. If I can divide this budget of 100 million or 1 million into purchasing home care services in this jurisdiction, most older residents will get access to home care services for 4 or 5 hours per week. This jurisdiction would be much better for older people to live in than the case with an extra residential building.”

Hao, government official at the sub-district level

#### 5.2.4 The market as supplement or alternative to families in home care practice

Care providers in the market have realised the preferences of older people on staying at home, the difficulties for adult children to provide care, and the opportunities for doing business in this field. The market has gradually stepped into the care provision field as a supplement or alternative to families. The interview data show a common view that the market provides support to families in the care provision dimension. In most cases, the market works more like a supplement to familial support when care workers and family members share the care duty for older people; in a few cases, when family members are completely unavailable for direct care provision or their economic background is good enough to transfer all care provision duties to the market, care workers then become the alternative for familial caregivers.

“The home care market is filling in the gap of care that can no longer be provided by families.”

Wang, care manager

“Non-state home care agencies help reduce the care pressure of adult children. If older people receive services from care workers at home or at a day care centre, their children can focus on their paid work in the daytime. Also, care agencies take some care duty off the government.”

Li, government official at the sub-district level

Considering the employment relationship in the care delivery process, the interview data show that older people and their families usually hire care workers through the introduction of personal contacts (e.g. relatives, neighbour, friends, community officials) at the earlier stage of development of the informal care market. There were no formal contracts between service users and care workers when the employment relationship started. Gradually, care staffing agencies emerged in the market offering professional introductions of care workers to older people and families. Increasingly, families pay these professional agencies to get

introduced to care workers. There are different types of agreements between service users and care staffing agencies: some are based on the success of introducing one care worker, while others are set for the instant introduction of care workers in a year (if previous care workers leave the job within the contract period, agencies must introduce a new one to replace the position).

Unlike the increasing application of contracts between purchasers and care staffing agencies or home care agencies, the employment contracts between service users and care workers are not widely applied yet. Even though service users and care workers may have (oral or written) agreements on the prospective length for the job, there is no liability for breaching it. There are risks embedded in this situation when service users and care workers have no formal contracts, during which the rights of both groups cannot be protected from dangerous behaviours or unexpected incidents. For example, a few local government officials argued that the maltreatment of some agencies or care workers against older people was difficult to monitor and track when there are no formal contracts (even in some cases, care workers provided fake personal information). The disputes on outcomes and regulatory framework will be discussed in Chapter 7 in greater depth.

Besides, contracts between care agencies and care workers are different based on the job description and the service frequency for each client. Care staffing agencies provide either long-term home care workers or hour-based care workers. For the former, long-term care workers (agreements with service users rather than care agencies) are introduced to different recipients (e.g. children, older people, maternity women) on a 24-hour basis or on a “pay as you go” contract (e.g. 8 hours per day). In this pattern, staffing agencies have “one-off” working connections with care workers, which usually involves no formal contracts between them.

For the latter, some home care agencies step into the care market with existing bounded working contracts with care workers. Exemplified with a case in my study, after being certified as a home care agency, a former care staffing agency turned from introducing care workers to providing hour-based care services. Later, this agency achieved commissions from several local authorities to work on state-paid home care projects (i.e. provide care services to a

package of older people on the list allocated by local authorities). Compared to the one-off “come and go” version, the latter one involves more long-term management of care workers by care providers while less bounds between care workers and service users. The arguments on the recruitment, retention and training of the care labour force will be discussed in Chapter 7.

The importance of subsidies to informal caregivers was also proposed by a few government officials. They suggested that the state should provide more encouragement than just oral support to family caregivers, such as tax concession, part of long-term care insurance, or other welfare accessibility. However, there is no subsidy for informal caregivers in Shanghai yet. Chapter 9 will discuss filial obligation in the marketisation context.

“No subsidies are targeted to family carers. If I stay at home to provide care to family members, I would be more positive and feel supportive if I can receive some social benefits from the state. Superior governments should take this into consideration for policy-making.”

Lei, community official

### 5.3 *Community Support in Home Care*

The term community applied in this thesis involves volunteers, neighbours, and community quasi-government function branches (*shequ*), who provide support and unpaid services to older residents. Residential and non-residential community care facilities are generally run by *shequ* or contracted out to independent providers like home care agencies. The empirical and documentary data suggest that the community is an important supporter of home care in Shanghai.

“If adult children are living far away from their parents, services from the community are significant in older people’s lives.”

Shang, community official

As shown in contested understandings of home care and community care (see Section 5.2), there was a popular view that the marketisation of home care benefits from community support in terms of volunteers and community officials (in local function branches), especially when their families are not available to provide enough care for them or when their purchasing power is not strong enough to get sufficient paid services from the market.

Community volunteers and officials provide emotional support, simple practical care (e.g. grocery shopping), or emergency help (e.g. sending to the hospital). This section focuses on the crucial role of the community in home care for older people from two aspects: the volunteer schemes and community quasi-government function branches.

### 5.3.1 Volunteer support for older people

Specifically, interviewees proposed positive impacts of community volunteer activities on older people's daily lives, such as the "neighbour pairing help scheme" (e.g. neighbours help older people on shopping and other activities, pay regular visits to check older people's health and living status), and volunteers from various companies and organisations who provide visits, financial support, emotional support, and so on. Among the volunteers group in Shanghai, interviewees argued that the "young-old volunteers team" (who are in their 50s or 60s) provides substantial support to the old-old group.

The importance of the role of young-old volunteers is gradually getting recognised by the state. For example, at the National People's Congress held in March 2017, several deputies proposed a motion to the central government on "making a 'service saving account' for young-old volunteers who provide support to old-old group, so they can get access to free care services (paid by the state) based on their volunteer contributions in earlier life". In responding to this proposal, the Ministry of Civil Affairs (2017b) suggests that some trial schemes like "time bank" are going to be set up to explore "saving and exchange" systems of care services, so as to encourage volunteers and mutual support among older people.

Volunteers from organisations or companies sometimes have working relationships with care providers or local governments. As suggested by several community officials, it is common for community branches (*shequ*) to receive material help (e.g. food, gifts) targeted to older people from various sources. Meanwhile, volunteers from these organisations sometimes also provide practical services (e.g. visits, health checking, chatting) through the cooperation with *shequ* or home care agencies.

"Except to care workers and administrative staff in our agency, we also rely on plenty of external volunteers. We recruit volunteers from the community and various companies

that have the willingness to support charity. Some companies provide volunteer support to older people relating to their working field, or sometimes outside of their field.”

Xie, marketing manager in a care agency

### 5.3.2 Community quasi-government functional branches

Quasi-government function branches at the community level (*shequ*) act as a forearm of the government (see Chapter 2), which is an active player in care practice in urban China. The fieldwork data show that one important work duty for community officials in Shanghai is to support older people and to cooperate with or coordinate volunteer groups. For example, community officials need to visit the old-old group or older people who are living alone in their jurisdiction every day (ideally in person, sometimes by phone calls).

The community branches work as a bridge between different groups. First, the *shequ* represents the forearm of local governments while holds plenty of first-hand information of residents. Older people and their families usually contact the *shequ* office as the first stage when they need to contact the government. Second, community officials work as a mediator between older people (and their families) and the market (care agencies and care workers). Complaints in practice about care quality, care relationship or other issues, are commonly addressed by community officials, while tricky problems would be reported to the superior government (i.e. sub-district) by the community. For example, if older people are unsatisfied with their care workers under state-paid projects, they (or their families) usually get to the community office to complain. The community would then report to superior government officials or directly communicate with care providers (the accountability of governments will be analysed in Chapter 7).

A specific case from the interviews is selected to illustrate the roles of community officials, volunteers, local governments, and care agencies in practice. Wang, a care manager, shared an incident that triggered the withdrawal of the commissioning of state-paid care schemes for this care agency in one sub-district, during which the community volunteer system and *shequ* officials play important roles in care practice on behalf of older people.

“Older people usually are paired with volunteers in the community. When they are unhappy about care services, they can talk to volunteers and community officials. Community officials update the information to *jiedao* (sub-district) very quickly. If the

## Chapter 5

### Home Care at the Central Position for the Marketisation of Care in China

complaint gets ‘fermented’, there will be severe consequences for us. The local government will have negative comments on the quality of services; the reputation of this care agency will get influenced in this area.”

Wang, care manager

Specifically, this incident was triggered by one care worker who asked older people to sign her working hours claim form in advance of services (which should be signed after the service each time according to the regulations, but she asked service users to sign for the whole month in advance). The care agency did not check on services provided by each care worker on a daily basis; instead, care managers assigned work tasks and followed-up through phone calls without face-to-face meetings or inspections. One old lady was unhappy with this care worker’s request and asked her paired volunteers (who were residents in the same community) to report violation behaviours of this care worker to the *shequ*.

Community officials then asked the agency to monitor all care services to make sure they are delivered according to regulations. However, as Wang said, this agency did not take action at the time of receiving the notice from the community. Before managers planned to deal with this problem, it had been reported to the sub-district government. Government officials at the sub-district level asked community officials to inspect all state-paid services provided in this area; later, community officials found similar violation behaviours against other older people. This sub-district government then stopped all contracts for this care agency immediately. After explaining and apologising to service users and local governments, promising to inspect the care delivery, and discharging the care worker, this agency got a warning of a two-month suspension of care schemes in this jurisdiction. Finally, after finishing the state-paid care service contract for that year, this care agency lost the chance to get care scheme contracts in this jurisdiction any longer (which is usually annually renewed if satisfied).

The above example shows the roles of community branches and volunteers in care practice. Community officials and volunteers not only provide free services to older people but also contribute to the inspection of care practice and mediate the relationship between older people and care providers. Regulating, monitoring and inspecting the care market (e.g. the care delivery process, service quality and care relationships) are imperative to protect older



people's rights (see Chapter 7), during which the community links different groups and represents the state in various ways at the front line (e.g. help implement projects, collect data, inspect providers' behaviours) and contributes to the process of marketisation.

### *Conclusion*

To explain why home care is at the central position in the development of the Chinese care system, this chapter has emphasised the persistent cultural norms of "filial piety" that contributes to the intergenerational supporting system within each family. As a moral obligation rooted in the Confucian family, cultural norms of "filial piety" allocate the care responsibility to families, which has been legislated in China. In the context of the growing difficulties for adult children to take care duty, this chapter has identified the stress of adult children in providing care. Considering the attitudes towards saving and consumption, the willingness for the current old-old cohort to purchase or to allow their children to purchase care services is generally low. Yet, regarding stronger purchasing power and more positive attitudes of younger cohorts, potential development of the care market has been suggested to expand when wealthier cohorts get older.

Home care matches preferences of the state and older people and their families. First, influenced by embedded family-centred cultural norms and economic concerns, older people and their families (as joint decision makers) prefer to keep older people staying at home as long as possible. Second, as the public budget holder, the state aims to purchase cheaper care services to save public funding. Based on the comparison of contested definitions of family care, home care, community care, and the structure of the care system, this chapter has examined the relationships between different care approaches. The central status of home care in the care system has been examined and the role of the market as a supplement or alternative to families in home care has been recognised. Additionally, the importance of volunteer schemes and the community quasi-government branches in home care practice and the marketisation process have been discussed.

**Home Care at the Central Position for the Marketisation of Care in China**

The focus of this chapter has been the direction of care policies and broad influences on the marketisation process. The next chapter will look in greater detail at the strategies adopted in Shanghai and the distinct models of marketisation that can be identified.

## Chapter 6 Emerging Quasi-Market of Home Care in Urban China

---

### *Introduction: Formation of a Quasi-Market*

Care for older people in urban China is changing from state-based monopolistic provision to the involvement of non-state agencies providing care with competition. To analyse the process of marketisation of care in urban China, this chapter starts from how care for older people is changing at care provision, finance, and regulation dimensions with the formation of a quasi-market. After the introduction of the formation of a quasi-market, Section 6.1 focuses on major processes of the marketisation of care implemented by the Chinese government, including financial support to providers and care recipients, and contracting out care services to non-state care agencies. This chapter identifies diverse models of contracting out strategies, financial support methods, the hierarchy of power in the care market, and how it influences the state-market relations in different jurisdictions. Section 6.2 illustrates three models (i.e. the state-controlled model, the limited competition model, and the free market model) with specific cases from the fieldwork, which involves the analysis of commissioning processes, reasons why local authorities adopted each model, and the nature and content of the state-market relations.

The concept of “quasi-market” was defined in the UK context when the government started to introduce market-oriented reforms to the welfare state in the late 1980s, as a market with competitive independent agencies replacing the monopolistic state providers (Le Grand, 1991; Le Grand and Bartlett, 1993). As Le Grand (1991) argued, quasi-market differs from the conventional free or pure market in one or more of three ways: not-for-profit and for-profit organisations coexist in the market and compete for public contracts; consumers apply vouchers for purchasing; and agents might represent the consumers in the market. Hardy and Wistow (1998) explored the initial quasi-markets of domiciliary care in England. Nyssens (2010) argues that quasi-markets that introduce market principles within the field of public policies have been observed across Europe since the 1980s. Quasi-markets involve the separation between the funder (the state) and the provider (diverse subjects), which is suggested to increase the efficiency in home care provision (Bode, Gardin and Nyssens, 2011).

These characteristics of the quasi-market emerge in the field of care for older people in Shanghai. Based on the documentary and fieldwork data, processes of the marketisation of care for older people in urban China represent all these three characteristics of a “quasi-market”. On one hand, the care system in Shanghai is no longer a monopolistic system provided by the state. The involvement of non-state care agencies has significantly increased since 2000. Those previous state-owned agencies have been contracted out to for-profit and not-for-profit organisations. To embody the nature of non-state agencies in the care market in China, the new term “social service agency” has been applied in the Charity Law of China (2016) to replace the old name of “people-run non-enterprise unit”. This thesis applies “social service agencies” to name non-state organisations in the care market.

Social service agencies in China are neither “private” in policy rhetoric nor “independent” from the state in practice. Interviewees in my fieldwork suggested that care providers generally rely on the state in different dimensions (e.g. funding, regulation, management). The role of the Chinese government in the field of care for older people has changed from a direct provider to a combination of funder, purchaser, and regulator. It turns into a combined role in the finance and regulation dimensions in the care system through contracting out care services rather than a direct service and funding provider. According to the informants in my fieldwork, a large number of care agencies in Shanghai which used to be operated by the government are now run by independent enterprises through the commissioning. Based on the interview data, almost all home care agencies in Shanghai are “social service agencies”, and the number of “private” care homes is growing as well.

On the other hand, the current care market in urban China is a quasi-market instead of a conventional market, which involves not-for-profit and for-profit organisations competing in the market, care service vouchers allocated by the state to older people to purchase from social service agencies, and community officials or care managers representing older people to make choices in the market. As summarised in Chapter 2, there are three main processes of the marketisation of care in the international context; namely, contracting out care services, financial support to older people and the care market, and direct purchasing by older people and their families with private funding. Among these three processes, this chapter

focuses on the former two strategies applied in urban China, as direct purchasing by older people and their families has been discussed in Chapter 5.

### *6.1 Processes of the Marketisation of Care in Urban China*

Inspired by theoretical and empirical knowledge of the marketisation of care in the international context (see Chapter 2), the analysis in this chapter is based on the empirical data collected from my fieldwork and supplemented by documentary data and existing literature in the care field (see Chapter 4). Referring to the brief context of home care described in Chapter 3, the Chinese government has been getting involved in the care market in recent years by applying marketisation strategies and setting up regulations. This section illustrates processes of the marketisation of care applied by the Chinese government in two categories: financial support from the state to older people (direct support to older people) and contracting out services and financial support to care providers (indirect support to older people). The mix of these marketisation strategies and the diversity of the care market at the local level are discussed in the last section.

#### *6.1.1 Direct financial support to older people*

Financial support from the central government and local authorities in the field of care for older people usually targets three main groups: service users, care providers, and care workers. The allocation of resources to older people is the direct support from the state, while the financial and policy support to care providers is an indirect way to help older people. As Yang (2011) argued, subsidies to social care agencies are designed to support older people to get access to care services and to reduce their financial burdens, especially for older people with physical and intellectual disabilities. This idea is based on presuppositions that financial support from the state can help care providers with their operating costs; social service agencies would set lower prices if they get the reduction on costs; and then care services would be correspondingly affordable (or at least cheaper) for older people.

Referring to characteristics of the quasi-market, Le Grand (1991) identified two processes: first, earmarked budget or vouchers are offered to service users to purchase in the market; second, the public fund shifts from direct allocation to providers within a bureaucratic

mechanism to purchase through a bidding process. This section discusses the empowerment of older people as service users through cash and non-cash financial support, which is the first of Le Grand's processes. Considering the direct financial support to older people to purchase care services, the Chinese government aims to support the most vulnerable groups among older people (see Chapter 5). Local authorities with independent finance (at the levels of provinces, cities, districts, and some sub-districts) have the discretion to include specific vulnerable groups based on their financial conditions and political priorities.

Considering the form of financial support to older people, both cash and non-cash support are provided in urban China. Based on my fieldwork data, non-cash financial support is usually allocated as vouchers for care services and basic grocery. Vouchers for services are counted as hours of care provided by care workers in older people's own homes, while vouchers for basic grocery are designed for older people to purchase food and essential items for daily life. As a consensus among my interviewees, the most common direct non-cash support applied in Shanghai is vouchers for care services (or directly allocating care workers to provide home care without actual vouchers but counted by community authorities or care agencies). The quotation below exemplifies types of subsidies for older people in one sub-district in Shanghai:

"Subsidies in our area include: First, state-paid services are designed to provide to the poorest group of older people; only a very small group is qualified for the criteria. Second, a new form in recent years: The Civil Affairs Department and the Health Department cooperate to provide nursing or rehabilitation services to older people in their own homes. Third, daily life support subsidies, such as meal delivery. In this case, local governments usually provide subsidies to private organisations on rents, decorations, and labour, as well as allocating subsidies to every meal they provide to older people. These (daily life support) projects have no standardised subsidy level, which usually depends on the negotiation between those providers and the local government."

Mai, executive of a care agency

There are increasing supporting policies available for older people in Shanghai. However, as discussed in Chapter 5, a chorus of local government officials and care providers that participated in my fieldwork criticised the coverage and the amount (20 or 25 hours per month) of state-paid home care for being insufficient. As many interviewees pointed out, the group of older people who were eligible for state-paid home care services only represents a

small picture when compared to the number of older people in need of external financial help to get access to home care services.

#### 6.1.2 Strategies to support the care market

The Chinese government has applied diverse strategies to support social service agencies in the care market. Based on pilot projects conducted across different cities in China, the Division of Social Security of the Ministry of Finance of China (2011) categorises the public purchasing of social services in three ways: public financial support to “people-run institutions” (defined as social service agencies from 2016) (*Mingban Gongzhu*), institutions established by the state to contract out to social service agencies (*Gongban Mingying*), and competitive purchasing by the state in the market. Yang (2011) illustrates that the model of “public financial support to social service agencies” (*Mingban Gongzhu*) implies that independent organisations or individuals establish care agencies by themselves with financial support from the state; the second model of “*Gongban Mingying*” is defined as the state building up facilities with public funding before commissioning to social agencies for daily operation.

The key distinction between these two models is who (the state or social service agencies) is the owner of properties and facilities of that institution: the state has the ownership of the agency and its real estate in the first model of *Mingban Gongzhu*; social service agencies own their own organisations and properties in the second model of “*Gongban Mingying*”. Li (2013b) proposes a more detailed classification, identifying multiple ways applied by the Chinese government to purchase public services, including contracting out, cooperating with the market sector, subsidies, voucher system, and so on.

Referring to the interview data, local government officials and care providers shared their interpretations on the different types of state support to care providers. For example, the quote below shows the personal understanding of one informant on contracting out care services based on her working experience.

“There are two ways to contract out (home care) projects: first, commissioning at the starting point of projects, at the stage of planning, establishing, or registration; second, transferring existing projects that used to be run by local governments or public agencies

to social service agencies. The transfer of projects at halfway involves the management of old employees, including administrative staff and care workers, which might lead to the situation of mixed human resources management of public and independent sectors within the agency.”

Qian, care manager

Comparing the marketisation strategies expressed in government documents with the views of interviewees in my fieldwork, contracting out care schemes to the market and allocating financial resources to social service agencies are the two main marketisation processes applied by the Chinese government (see Table 6.1). First, the state contracts out either the ownership of existing public institutions or specific care service projects. In this category, the former strategy transfers the property ownership to the private sector, while the latter one only contracts out the operation and management power to the market while keeping the ownership of agencies to the state or the community. Second, the state provides financial support through various subsidies to care providers (independent agencies or public-private joint ownership agencies), such as subsidies based on bed numbers or service delivery frequency, reduction on bills (e.g. water, electricity), and tax reduction.

The state is an important funding provider for different types of care agencies based on the mass purchase of care services with the public funding. Even though the funding from the state is at different levels for each type of agency, financial support from the state is generally an important source for home care agencies in China.

“The state has given a lot of help to the market. Many market organisations started their business based on the financial and policy support from the state.”

Qing, owner of a care agency

Specifically, in Table 6.1, I classify frequently quoted strategies in policy documents (column 2) into two marketisation themes (column 1). The sequence of policy strategies under each theme is based on the ownership of the property from the public to the private (column 3), which is highly correlated to the independence level of agencies: institutions that involve more public funding are allocated upper rows, while fully private properties are in the lowest row. The last column shows funding sources for care agencies. As presented in Table 6.1, there are varied types of home care agencies, involving different combinations of



commissioning methods, levels of financial support from the state, and relations with the state.

*Table 6.1 The marketisation strategies and categories of home care providers*

<b>Marketisation themes</b>	<b>Policy strategies</b>	<b>Property ownership</b>	<b>Funding source</b>
<b>Contracting out care services</b>	Contracting out existing public agencies	Public	Institution established by the state, Public purchasing of care services.
	Public funding & private provision	Public	Institution established by public and private joint funding, public purchasing of care services.
	Service projects commissioning	Private	Institution established by private funding, Public purchasing of care services.
<b>Financial support to social service agencies</b>	Joint stock	Public & Private	Public funding for the public section within care agencies; Private funding for the private section; Subsidies for the private section.
	Joint investments for the establishment and operation of agencies	Public & Private	The state provides estates & in some cases partly funding; Private funding.
	Private investments for the establishment with public support	Private	Private funding; Government subsidies.

After the Chinese central government appealed to develop home care in 2006 (see Chapter 3), local jurisdictions started to introduce regional policies and schemes to encourage private capital to establish or operate social service agencies in the field of care for older people.

Shanghai Municipal Government (2016a) lists common policies on supporting independent care institutions for older people (including home care agencies and residential agencies): tax reduction or exemption for social service agencies, water and electricity bills to be paid for residential use (cheaper) instead of commercial use, discounts applied for renting or purchasing estates with welfare use (cheaper than commercial use), and sometimes free land allocation for welfare institutions to build up facilities. Interviewees also demonstrated similar marketisation strategies they had experienced in practice.

“Financial support focuses on the hardware facilities, such as subsidies to building-up fees of care agencies, operation subsidies, subsidies for rents; and the software, including social security allowance for employees in care agencies, care worker subsidy, reimbursement for care worker training, support for purchasing insurance for care workers.”

Jiao, government official at the sub-district level

As shown in Table 6.1, it is a common strategy applied by the Chinese government to purchase care services from different types of agencies. The Division of Social Security of the Ministry of Finance of China (2011) indicates that the state purchases social services through two common ways: investing to create job positions and purchasing services from social service agencies. For the former, local governments invest in job-creating and vocational training for care workers. The interview data suggest that the reason why the Chinese government started to give priority to enhance the employment rate in the social service sector is to address a large number of laid-off workers in urban China in the 1990s. These laid-off workers are named the “40/50 group”, female workers older than 40 and male workers older than 50. The “40/50 group” lost their previous jobs because of the economic reforms of state-owned enterprises from the 1990s (see Chapter 3).

In this context, local governments targeted the creation of new jobs for the laid-off group, which subsequently promoted the care provision for older people. For example, the Shanghai government started to purchase job positions (i.e. allocate a specific amount of funding to the agency if they get one employee in specific positions), invest in job training, and purchase services in the welfare sector from 1998 (Civil Affairs Bureau in Shanghai, 2000). As argued by most of my interviewees, a substantial number of the 40/50 group had taken jobs as care workers for older people in Shanghai.

For the latter, local governments in urban areas in China increasingly apply the methods of purchasing social services from the market. According to a study conducted by Fan et al. (2010), the government of Gulou District in Nanjing (the capital city in Jiangsu Province) managed to fulfil the care needs of older residents living alone at home, by providing financial help for them to purchase home care services and day-centre services from social service agencies. Public purchasing is embedded across different models of the care market in urban China, which is discussed in-depth on the models of quasi-markets in Section 6.2.

#### 6.1.3 The diversity of the care market at the local level

According to the interview data, even though contracting out care services from the state to care providers is widely applied in Shanghai, guidelines on the procedure of contracting out and financial support are not generalised at the city level. Regarding the political management hierarchy in Shanghai (see Appendix 3), there are 16 districts, 213 authorities at the sub-district level (i.e. 104 *jiedao* in urban districts, 107 towns and 2 villages in suburban districts), and 5681 communities (Shanghai Municipal Government, 2016b). Within the political system, local governments at sub-district (*jiedao*) level have the autonomy to choose providers to take the state-paid home care schemes in their jurisdictions. Delegations of the power provide variances of the care market in each jurisdiction in Shanghai. In this context, localised characteristics of sub-district governments (e.g. management style, priorities in policy agenda, and personal preferences of government administration at management level) result in different choices of the contracting out, purchasing and following of regulating processes.

The Division of Social Security of the Ministry of Finance of China (2011) suggests that public purchasing on social services involves two independent subjects: the purchaser and the provider, who theoretically ought to be bound in an equal contract relationship instead of a subordinate relationship. Policy documents point out that the public purchasing process and other supporting strategies applied by the state in the market should follow a standardised procedure through the competitive bidding methods. According to the fieldwork data, the commissioning based on competitive bidding is becoming increasingly popular but not dominant yet. In the report of the Ministry of Finance of China (2011), it is proposed that the development level of the market and the regulatory methods of local governments lead to

diverse and complex relationship models in the public purchasing of social services. The complex relationship between the state and the market in China is discussed with case examples from the fieldwork in Section 6.2.

Data gathered in Shanghai demonstrated that sub-district governments are the major implementers involved in the practical procedure of care for older people (e.g. contracting out care service projects, allocating funding, evaluating service quality), while public policies in the field of care for older people are usually made by the central government, the municipal government, and sometimes the district governments. The practice level (sub-district) and the policy-making level (central and city) are generally separated in Shanghai. Government officials at sub-district or community level rarely participate in the policy-making process. The accountability of the state and the gap between policy-making level and the implementation level will be discussed in Chapters 7 and 8, respectively.

In the context of the separation of policy-making and practice, on one hand, there are concerns about the contradiction between diversities of local jurisdictions (*sub-district*) and the communal policies across the city. Local characteristics and diversities were emphasised by a few local government officials during interviews. They suggested that distinctive local characteristics should have been taken into consideration by policymakers, such as the demographic composition of residents, economic backgrounds, number of residential care homes.

“There are interactions and contradictions between local needs and municipal government policies.”

Hao, government official at the sub-district level

“Government policies should have taken more local features of different areas into consideration. Superior governments (city, district) should have allocated more flexibilities to the local administrative governments at the sub-district level.”

Wei, government official at the sub-district level

On the other hand, even though plans and policies are made by the central and municipal governments, the allocation of funding and detailed application strategies are controlled by local governments. The interview data show that the preferences of local governments inevitably have significant influence on the care market, which might lead to the inequality

between care providers. Many interviewees who worked in different jurisdictions across Shanghai had a common view that local governments (sub-district) usually prefer to solve several problems at the same time rather than considering care for older people as a single topic with in-depth and long-lasting support. It is inevitable that local governments only focus on issues in the bounded jurisdiction with little concerns on a larger area. As mentioned in the previous section, most local governments invested in creating care worker positions from the late 1990s because of the low employment rate at that time; some local jurisdictions decided to develop local care agencies as an administrative achievement rather than concerning the welfare of older people. In this context, some local government officials were critical that policies and strategies were separately applied within each small jurisdiction, which constrains the development of the care market and care for older people.

“Current public policies are not ‘public’, instead, they are restricted in small jurisdictions. We (sub-district governments) are only allowed to provide services to older people who are registered permanent residents in our jurisdiction. Even if some older people have lived in this jurisdiction for 10 years, if their ‘*hukou*’ (i.e. household registration) is not registered in this area, we cannot include them in our target group.”

Zhan, government official at the sub-district level

Local governments act differently when having the autonomy to take action in each jurisdiction, which leads to different outcomes in practice. Government officials who participated in my fieldwork suggested the “positive competition” and the “happy medium” as two types of potential outcomes based on their working experience. The interview data show that some sub-district governments tried to achieve in the field of care for older people by “active” strategies, such as allocating more attention, setting as a priority, expanding investment. As argued by Jiao (a government official at the sub-district level), the field of care for older people was not a common priority for politicians, especially when compared to the economy, commercial, housing, and many other fields. In this context, he suggested that it would be easier for local governments who would like to take actions in the field of care for older people to reach a better model than other jurisdictions. My fieldwork data shows that a few districts in Shanghai had more interest in developing the welfare field than others, while a few sub-districts had already achieved a good reputation in their jobs in encouraging home care for older people.

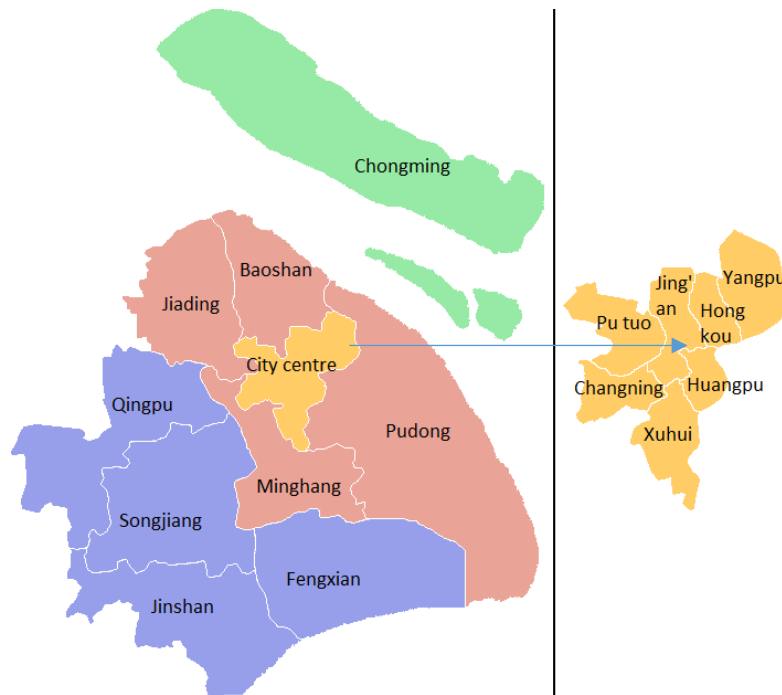
Additionally, strong cultural norms underpin local government officials' choices in the process of care policy implementation. As emphasised by a few local government officials, keeping the role as a happy medium is a common cultural and political philosophy in China. A government official at the sub-district level cited one Chinese proverb: "*Inequality, not scarcity, which persecutes people.*" He explained that local governments could not provide more services or financial support for residents in their jurisdiction even if the sub-district government was capable of provision and funding, because the increase of welfare in one sub-district would lead to the discontentment of residents in other jurisdictions. The interview data demonstrate that local governments usually give top priority to the ideas of "equity", "universality", and "stability", which are embedded in the socialist roots and some Confucian ethics. Influenced by these ideas, it was suggested that many local government executives focused on avoiding unsatisfactory complaints from different groups, rather than making aggressive movements to develop home care. Considering the local characteristics and convergences of marketisation strategies among sub-districts in Shanghai, the next section discusses models of marketisation with examples from my fieldwork data.

### *6.2 Marketisation Models and the Hierarchy of Power in the Care Market*

Considering local diversities in sub-districts (*jiedao*) in Shanghai, this section identifies marketisation models based on cases from my fieldwork in terms of contracting out strategies, financial support methods, the hierarchy of power in the care market, and how it is shaping the state-market relations. Drawn from experiences and viewpoints of participants in the fieldwork, three models are illustrated in this section; namely, the state-controlled model, the limited competition model, and the free market model. The characteristics of each model represent different relationships between the state and the market and specific supporting strategies applied by local governments.

In general, the fieldwork data show regional characteristics of the coverage of care agencies: local agencies and large for-profit agencies coexist in most areas in Shanghai; care providers compete fiercely at inner districts (i.e. 7 districts in the old city centre and Pudong District, see Figure 6.1); the development of home care agencies in other outer areas started later than central districts; smaller care agencies were more likely to drop out during the

competition with growing large for-profit providers in most areas; while a few areas were dominated by smaller local agencies.



*Figure 6.1 Shanghai administrative districts map*

*Source: Wikipedia*

*Notes: Among 16 districts in Shanghai, 7 districts (i.e. Huangpu, Xuhui, Changning, Putuo, Jing'an, Hongkou, Yangpu) are the traditional city centre. The part of Pudong District adjacent to the traditional city centre is defined as the new inner area together with the traditional city centre of 7 districts. Jiading, Baoshan, Minghang, Qingpu, Songjiang, Jinshan, Fengxian, and part of Pudong are outer districts of Shanghai.*

#### 6.2.1 The state-controlled model

I categorise sub-district cases that appoint one pre-determined agency as the preferred supplier with low-level competition involved as the state-controlled model. In the state-controlled model, local governments allocate contracts of care service projects and resources directly to the chosen agencies. In turn, appointed care providers follow all instructions from the local government. In this model, care services are no longer provided by public agencies or state-owned enterprises as in the traditional monopolistic state provision, whereby social service agencies are involved in the low-level competition.

Practical issues in terms of care provision (e.g. daily operation and recruitment of care workers) are managed by care providers, which was suggested to help the state work more efficiently in other domains (i.e. regulation, finance). During interviews with government officials and care providers involved in the state-controlled model, they argued that local authorities pay more attention to the efficiency and quality of care services in the quasi-market than in the previous period when dominated by public provision. Even though service contracts and financial resources are allocated to the pre-determined agencies, owners and managers of agencies argued that they had been aware of risks and competition, because of the budget ceiling, strong control of the state (e.g. local governments set up detailed requirements on the coverage of care services and program content), and potential risks of losing the trust and contracts of the local government.

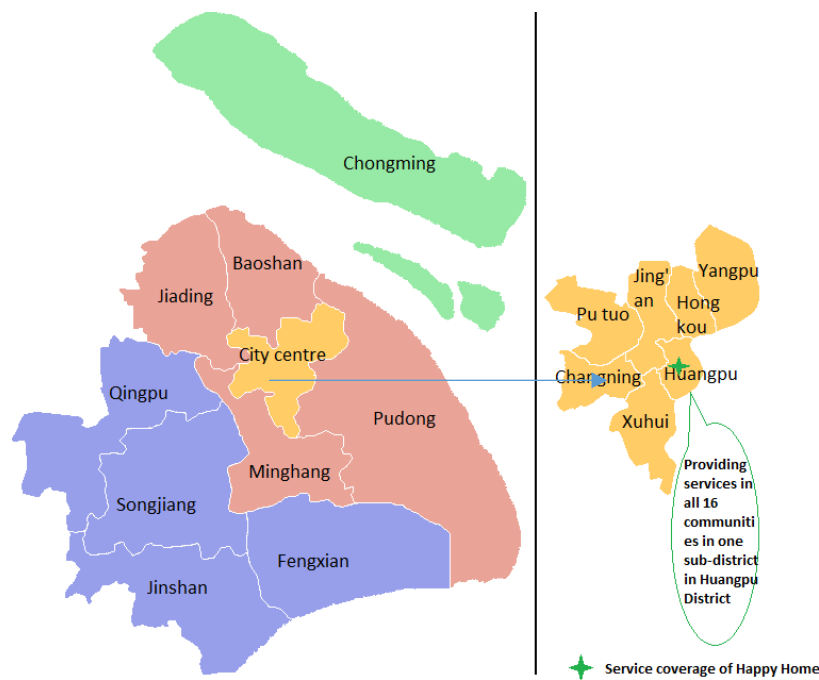
Some government officials suggested that care recipients benefit from the state-controlled model, because the government has high-level control and inspection over the service quality and delivery process. However, it was a consensus that the strong government control has restrictions on the development of the care market. The decision-making process of local governments in this model is a “black box”, which designates care service projects to one provider without any open competition procedure. Contracting out without open competition might lead to insider-dealing and corruption. As suggested by Qing (an executive of a care agency), allocating all projects to one designated agency is in-house commissioning rather than a real contracting “out”. In addition, when fully controlled by the state, care providers not only gain resources in the area but also administrative burdens and restrictions from the local government. For example, these care agencies cannot provide services to privately paid customers without the permission from local governments. Interviewees also suggested that the expansion of care services to other jurisdictions (e.g. neighbour sub-districts) is not possible for agencies involved in this model unless they get approved by the local government, which is rarely granted.

*Case study example: The state-controlled model in Sub-District Rui*

In Sub-district Rui of Huangpu District, the local government provided a state-owned estate to help establish a local agency “Happy Home” in 2008. All state-paid home care projects in



Sub-District Rui have been exclusively appointed to “Happy Home” since it was founded. This local agency currently only provides care services in this sub-district (see Figure 6.1). Working connections between Sub-District Rui government and “Happy Home” are substantially tight. For example, when older people or their families seek advice from the community branches (*shequ*) on purchasing care services (e.g. employment of care workers, where to find care services with decent quality), community officials said that they always introduce “Happy Home” to residents for direct purchasing.



*Figure 6.2 The state-controlled model in Sub-district Rui and agency “Happy Home”*

As summarised in Table 6.2, the government in Sub-district Rui helped establish “Happy Home” and contracted out all state-paid care schemes to this provider. The property of “Happy Home” is owned by the local government and has been operated by the same social service agency since its establishment. This model involves strong control from the local governments and low-level competition in the care market.

*Table 6.2 The pattern of care agency “Happy Home” in Sub-District Rui*

Agency	Contracting out methods	Property ownership	Funding source	Power relation	Service coverage
Happy Home	Public investment & private provision ( <i>gongban minying</i> )	Public	1. Local government provides the estate; the majority of establishment costs; public purchasing.	1. Strong state control; 2. Low competition	One sub-district
	Project commissioning		2. Private: small-scale investment for agency establishment; operation costs.		

*My fieldwork recruitment process & state-market power relation*

Different state-market power relations are embedded in the characteristics of each model of the quasi-market. Referring to my recruitment process of interviewees in the fieldwork (see Chapter 4), I examine the power relations reflected in the process and interpretations of interviewees, illustrating with specific case examples.

The Sub-district Rui government plays a supreme role in the contracting out and care provision process, which was reflected in my fieldwork data. Regarding my recruitment process in Sub-district Rui, first, I contacted one care manager in the “Happy Home” agency through a personal contact. When I asked the care manager to introduce government officials in this area at the sub-district level or community level to join in my study, she explained that she would like to invite but she was unable to do it successfully, because the position of care providers was obviously lower in the hierarchy than government officials. The owner of this agency also told me that they usually only accept interviews if local government officials asked. I was the first individual researcher who directly contacted the agency without an introduction from the sub-district government. Thus, I did not move on to conduct interviews with government officials through the agency’s introduction.

Coincidentally, after several weeks, I received an opportunity to interview the vice-chairman who was in charge of welfare issues in this sub-district with the introduction from an academic (another personal contact). As a government official at the management level, this vice-chairman easily introduced me to a few community officials and care agency managers who worked in this jurisdiction and/or in other areas. The relationship between him and community officials and those care providers indicates a superior-subordinate hierarchy. During the interview, this vice-chairman argued that community officials do not have in-depth thoughts about policy or practice of care for older people. He cited a Chinese proverb: “*too exhausted for the life and missions (pi yu ben ming)*”, explaining that the heavy work duty and low life quality lead to little active intentions for community officials to explore beyond their day-to-day tasks. I anticipated that community officials might defend the importance of their views and insights in the care sector. Unexpectedly, the vice-chairman’s idea got many supporters at the community level (without knowing what he commented). For example, when I asked a community official about the needs in care practice and her comments on care policies, she said:

“It is not what I should consider. My job only needs to follow any instructions allocated by the *jiedao* (sub-district). There will be no benefits to me or to others if I consider these issues in practice, not to mention in policy.”

Shang, community official

Nevertheless, there were a few community officials offering more active personal views on the front line job at the community level. They suggested that community officials play an active role in gathering practice information, providing feedback to superior governments, as well as trying to participate in the decision-making process. According to my fieldwork data, younger community officials who were in their 20s and 30s had deeper thoughts about the practice and made more efforts to get involved in the decision-making process than groups in their 40s and 50s. For example, after sharing her experiences of attending a forum focusing on care practice held by the district government, Ying (a community official in her 20s) argued that their experiences and views in practice are important and gradually taken into consideration by superior governments. On the contrary, in the same sub-district, Lei (a community official in her 40s) argued that the duty for community officials is to finish tasks

allocated by their line managers, rather than thinking about more in-depth topics about care practice or policy.

*Processes and reasons to adopt the model*

This section explores the rationale behind the model chosen in Sub-District Rui based on interviewees' interpretations. Supporters of the state-controlled model emphasised that high-level control from the government efficiently monitors behaviours of care providers. Government officials who support the high-level control model proposed reasons for making this choice: prompting care providers to allocate more attention to genuine caring for older people instead of exclusively chasing profits, and assuring the quality of services provided by those agencies. For example, the vice chairman of Sub-district Rui emphasised that concerns on the public welfare and keeping the power of local governments over the care market are the main reasons for why the sub-district government chose this agency:

“At that time (2007), we (this sub-district) were a pioneer in applying the contracting out strategy in Shanghai. No matter which methods we chose, it would be a pilot model in Shanghai and for China. When we decided to support to establish the agency “Happy Home” and to purchase services from it, we have several concerns. On one hand, we prefer to support an organisation who really cares about the welfare of our residents. We need to know their ethos and development plans. On the other hand, we want to make our sub-district as a top case in Shanghai. We do not trust strangers outside of the public system because there are many providers in the market who only take the job for money instead of good will. As you can see, ‘Happy Home’ is now a top home care agency in Shanghai. Plenty of visitors come to our sub-district to learn how we organise home care schemes. That is the acknowledgement of our efforts in these years.”

Hao, government official at the sub-district level

“Happy Home” was recognised as a “top model” care agency by Shanghai Municipal Government for its reliable performance in service quality, the satisfaction rate of service users, cooperation between the state and the market, and the increasing care provision in these years. More specifically, as government officials in Sub-district Rui and managers in “Happy Home” suggested, the content and quality of services in this agency have a good reputation in Shanghai, receiving positive feedback from older people and other residents in this jurisdiction. Also, the interview data suggest that the cooperation between this local government and the social service agency had proved to be an efficient model. Interviewees involved in this case were generally proud of their decision or performance.

Inevitably, this state-controlled model relies heavily on intentions and capacities of the local government. As discussed above, the government of Sub-district Rui tried to set up an outstanding case among all sub-district authorities in Shanghai, through high control over the “Happy Home” to make sure their instructions are fully carried out. However, it is difficult to figure out real intentions of government officials without transparency and openness. There are potential risks underlying this model. For instance, government officials might focus on gaining local or individual profits for this jurisdiction or themselves, instead of improving the care provision and financial support to older people and protecting their rights and welfare.

Meanwhile, care providers in the state-controlled model lack independence and negotiation power with local governments, which might strangle the ambition and further development of these agencies. For example, “Happy Home” tried to add new types of home care services (e.g. bathing) in their service list, but the sub-district government rejected the proposal. In this case, care providers argued that they created new services based on care needs of older people and their confidence in the capacity of the agency to provide relevant services. However, Sub-district Rui government rejected because of worries about the risk control of the care delivery. The local government explained that they considered the safety of older people (e.g. potential accidents that older people might fall off and get hurt during the bath, which would lead to increasing complaints). Managers of the care agency argued that it is worth taking these kinds of risk in the care provision process.

The independence of care agencies in the state-controlled model is difficult to achieve because it is contrary to the original intentions of government officials who chose this model. Nevertheless, preferences and choices of local governments on the marketisation model are not fixed, and can possibly shift to other patterns at different stages.

#### 6.2.2 The limited competition model

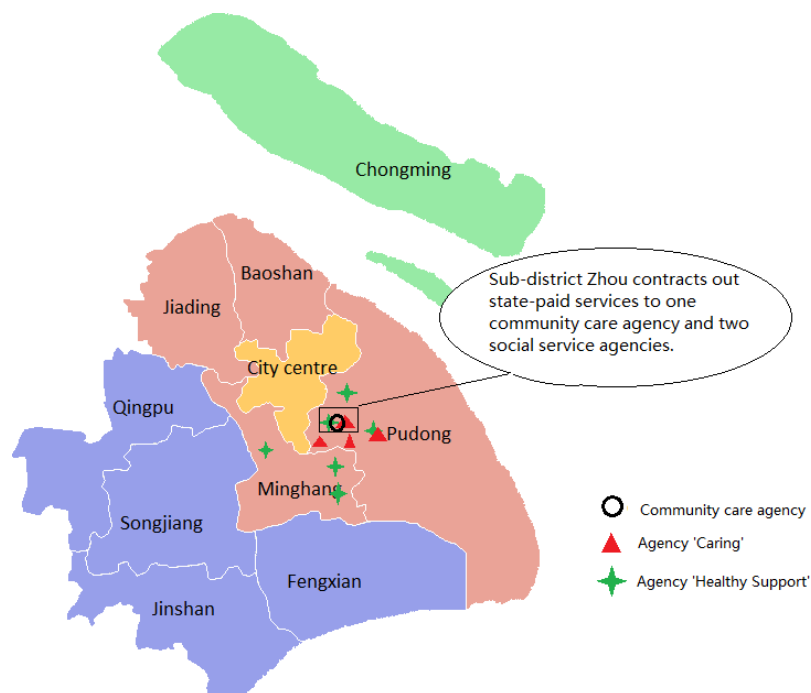
In the limited competition model, local governments select a small number of providers to compete for contracts on home care services for older people in each jurisdiction. Compared to the state-controlled model, local governments allocate contracts to more than one agency for competition, comparison, and evaluation. Local governments are more likely to change contracting out decisions based on reviews of care providers in the previous period.

Meanwhile, care providers involved in the limited competition model have more independence than those in the state-controlled model.

Yet, it is still a state-led model because local government officials have the power to choose care providers based on their personal preferences and set up flexible criteria that might change without counselling those agencies. For example, some local governments prefer to involve several local agencies for competition, while some allocate home care projects to various categories of care agencies (e.g. small local, large for-profit chains, public). The criteria and process of how the local government chooses providers are not open to bidding groups. Government officials at the management level act as players who are capable of setting up parameters in the contracting out process.

*Case study example: The limited competition model in Sub-district Zhou*

The idea of the limited competition model in this thesis draws inspiration from the case of Sub-district Zhou in Pudong District. In this sub-district, commissioning from the government on state-paid home care schemes are shared by three care agencies: one community agency and two social service agencies.



*Figure 6.3 The limited competition model in Sub-District Zhou and involved agencies*

The community agency, which is called “Sub-District Zhou Community Home Care Service Centre”, is directly managed by Sub-District Zhou. This community agency is not a department in the government, yet, the sub-district government fully controls its operation (e.g. staff recruitment, service amount, management). Two social service agencies, “Caring” and “Healthy Support”, are independently operated care agencies providing services in Sub-District Zhou. “Caring” is a local care agency providing services to people at any age group in Sub-District Zhou, established in 2000 with private funding. “Healthy Support” was established in 2012 with private funding and subsidies from the state. These two social service agencies started taking the commissioning of care service projects from Sub-District Zhou in 2013. The patterns of these three agencies are illustrated in Table 6.3.

*Table 6.3 The different patterns of care agencies in Sub-District Zhou*

Agency	Contracting out methods	Property ownership	Funding source	Power relation	Service coverage
<b>Community Home Care Service Centre</b>	N/A	Public	Direct allocation by the state	Strong state control	One sub-district
<b>Caring</b>	Project commissioning	Private	1. Private investment and operation; 2. Public funding and subsidies for state-paid services.	1. state control over projects; 2. Mid-level competition	Four sub-districts
<b>Healthy Support</b>	1. Private establishment with public support ( <i>minjian gongzhu</i> ) 2. Project commissioning	Private	1. Private establishment with government subsidies; 2. Public funding and subsidies for state-paid services.	1. state control over projects; 2. Mid-level competition	Six sub-districts

*My fieldwork recruitment process & state-market power relation*

The relationship between the sub-district government and care providers in the limited competition model is mainly led by the state. It is no longer a monopolistic care provision by a government department, nor one agency taking all care projects and being fully controlled by the government as in the state-controlled model. However, the local authority is still an overarching leader for these care agencies in the limited competition model. For example, compared to my interviewee recruitment experience in other cases, my recruitment procedure was much more efficient in sub-district Zhou, since I started from a government official at a higher level in this sub-district. When he introduced me to these care providers, managers treated it as an assignment, even though I and the government official himself had informed them it was a voluntary participation. The access to care providers and other government officials was much easier with an introduction from government officials at the management level.

As discussed in Chapter 4, I applied purposive sampling and snowballing technique to recruit participants. In this case, I first got the chance to interview a government manager through purposive sampling with the introduction of my personal contact. The following recruitment of community officials and care providers in this area acted as a snowballing process in a “top-down” path, as their relationship shows an obvious layered hierarchy. Based on my fieldwork experience, the snowballing sampling in the “top-down” path (from superior government officials to community officials and care providers) is much easier than in the “bottom-up” path (from care agencies or community officials to local authorities).

Regarding the arguments of government officials at Sub-district Zhou, the local government tried to keep the management power in the care provision process to supervise and monitor care providers. Government officials explained that the reason why they chose this model was that they do not trust these “private” agencies (disputes on for-profit motivations of care providers will be discussed in Chapter 7), especially in the context of when general regulations are not available. Specifically, Zhan, a government official at the sub-district level, shared his understanding on why the Sub-District Zhou government decided to keep strong influence in the field of care for older people at the current stage and potential changes in the future:



“I believe that the state will eventually rely on the methods of marketisation, which is an inevitable direction. We keep talking about cutting administrative departments and giving power to the society or the market, but we are not able to achieve it now. Why? There are two reasons: First, we dare not delegate to social organisations. We do not trust them, because they are always profit-driven, seeking to maximise their benefits. We are afraid that we will not be able to effectively regulate or restrict the market once giving too much power to them. Second, the state needs more time to set up regulations and laws to prevent potential problems. The resource allocation made by the market is an optimal way. The future direction is marketisation, inevitably. But we need more time.”

Zhan, government official at the sub-district level

My recruitment process reflected the hierarchies in the relationship between local governments and care agencies in the limited competition model. The behaviours and decisions of local governments in the contracting out procedure were not explicitly regulated by legal or formal rules. In some cases, government officials interfered in the bidding process. For example, a government official at the sub-district level said, *“I sometimes need to modify bidding reports for agencies and teach them to design their organisations and service plans. Their knowledge about the field is limited.”* Care providers always accepted his guidance without any doubts. In general, the management teams of care agencies at the early stage of development have less experience in the field of care for older people than government officials who have been at management level in the welfare field for years. Those experienced government officials at the higher level have influential impacts on affairs in younger agencies.

#### *Processes and reasons to adopt the model*

In terms of the case in Sub-District Zhou, the local government established the Community Home Care Service Centre in 2003, to take the responsibility of providing home care services to low-income older people in this jurisdiction. As discussed in Section 6.1.2, indirect financial support to care agencies includes creating care worker positions, which is a common strategy applied by local governments in the welfare field. The primary objective of the local government at Sub-district Zhou for setting up this agency was to create jobs for unemployed or “laid-off” residents, while the support towards older people is its positive “spill-over” effects as an extra bonus. Employees (care workers and managers) in the community care agency were all 40/50 workers who re-entered the labour market after being laid-off because of state-owned enterprise reforms.

The care needs of older people had not been evaluated in this sub-district at the starting point in 2003. The Sub-district Zhou government tried to cover the poorest group who were already in their priority supporting list, such as recipients of the “Minimum Living Standard Guarantee (*dibao*)” program (Chen et al., 2013), targeting the group whose income is lower than the minimum livelihood line set by local governments (e.g. ¥880 RMB that equivalent to £96.8 per month per person in Shanghai in 2018). The number and coverage of care recipients gradually increased in the following years. However, the size of the 40/50 group is dramatically decreasing in terms of retirement (retirement age in China is 50 for female workers, 55 for female officials, and 60 for the male; where female care workers retire at 50). This community agency can no longer provide enough care services to meet the increasing care needs in this sub-district. In this context, the sub-district government decided to contract out part of the home care projects to social service agencies.

To improve the efficiency as well as keep a high level of inspection and monitoring by the state, government officials in Sub-district Zhou decided to involve limited competition into the care field. Before posting the bidding information about home care projects for contracting out on the public advertisement platform at the district level, the Sub-district Zhou government investigated home care providers established in their district (i.e. Pudong). Two chosen local agencies (“Caring” and “Healthy Support”) had been invited to discuss their bidding proposals with local government officials before the bidding procedure. In fact, these two agencies are the default options for the contracting out in this sub-district, while the bidding process is no more than the formality of their decisions.

Even though these government officials chose agencies to participate in the unopen and pre-determined bidding process, they did wish to encourage competition between agencies. When government officials at Sub-district Zhou made choices among care providers, they purposively chose one small local agency (“Caring”) that had delivered home care to older people in this sub-district and its neighbourhood jurisdictions through direct purchasing by older people since 2000, and a midsize provider (“Healthy Support”) that had provided home care services across two districts in Shanghai since 2012. In care practice, the Sub-district Zhou government regulates and inspects home care services delivered by these agencies during the

process. They set up an annual renewal of contracts that requests satisfied performance in each period. The balance between these two agencies was controlled and changed by the sub-district government based on their performance in the previous year. Thus, there is peer pressure and competition between chosen care providers involved in this model.

### 6.2.3 The free market model

The free market model involves competition between different agencies based on the open bidding of home care projects. Market principles are more representative in the free market model than in the state-controlled model and the limited competition model. The interview data suggest that the free market model has been progressively applied across different jurisdictions in Shanghai in recent years. Increasingly, sub-district governments have established professional offices to deal with public purchasing issues in the social service sector (e.g. health, care for older people, support to people with disabilities). Meanwhile, district governments in Shanghai organise public bidding websites to advertise these contracts. In theory, government officials who have working connections with other stakeholders (especially independent for-profit providers) in social service practice are not allowed to interfere in the contracting out and resource allocation process.

In the free market model, large for-profit care agencies are generally more likely to win contracts than small local agencies, because they are equipped with stronger teams and more resources to impress decision makers in the bidding process. Referring to the state-controlled model and the limited competition model, local governments usually have preferences to support local agencies, to increase employment rates in their jurisdictions, and to directly supervise and control the care provision process. On the contrary, when the bidding procedure of care service projects in several sub-districts is managed by a central department for the whole district, efficiency is the main consideration instead of supporting local agencies or other local and personal preferences.

#### *Case study example: large for-profit home care agencies*

Large for-profit home care agencies are significantly growing with the increasingly open and competitive bidding system. For example, “Loving Care” is a large for-profit home care agency established in 2008 in Shanghai, which provided home care services in five districts in

Shanghai when I conducted the fieldwork in 2016 (see Figure 6.3 and Table 6.4). However, according to the interview data, getting the commission from local governments was very difficult for “Loving Care” until a few years ago. This agency did not reach the balance of income and expenditure until 2011 when the Pudong District government started the open bidding process for 30 home care projects. After receiving care scheme commissions in several local jurisdictions at the same time, “Loving Care” started to expand its coverage and influence in Shanghai.

This section draws characteristics of care providers dominant in the free market model based on three large for-profit home care agencies recruited in my fieldwork (see Figure 6.3). The fieldwork data shows that these large for-profit care agencies have grabbed a substantial share in the field of care for older people in Shanghai. As illustrated in Table 6.4, the project commissioning is the main contracting out methods for all these three providers, whereby local governments provide funding for them through purchasing services. Except for the public purchasing based on commissioning of state-paid care services, “Loving Care” received government subsidies for the establishment, while “Harmony Family” was partly funded by the state through providing long-term cheaper rents for its estates. Unlike the other two care agencies, “Pine Tree” was established in Beijing as the first “private” for-profit home care agency in China, which has extended to provide care services in other cities, with Shanghai included.

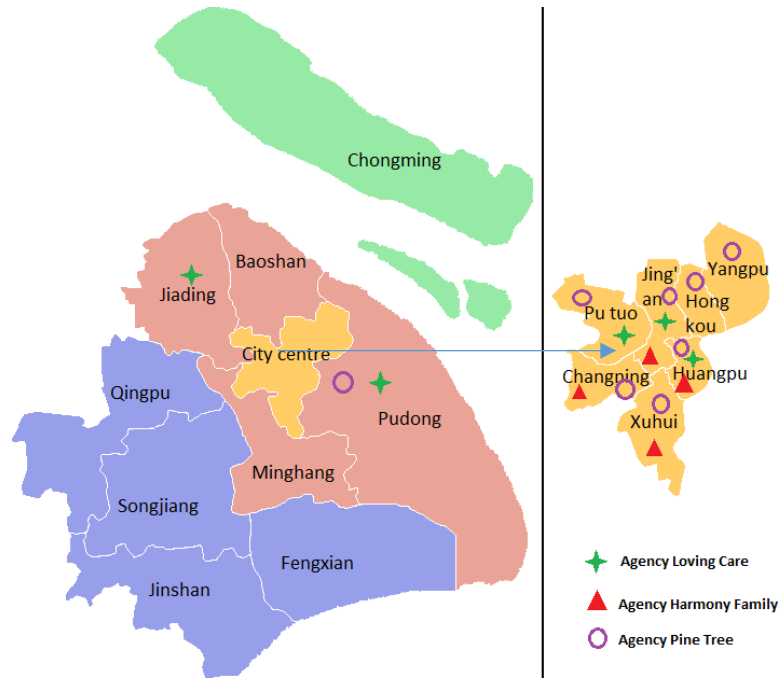


Figure 6.4 Coverage of three large for-profit care agencies in Shanghai

Table 6.4 The patterns of three large for-profit care agencies in Shanghai

Agency	Contracting out methods	Property ownership	Funding source	Power relation	Service coverage
Loving Care	1. Private establishment with public support 2. Project commissioning	Private	1. State subsidies; 2. Public purchasing; 3. Direct purchasing.		Five districts in Shanghai
Harmony Family	1. Joint establishment & joint funding 2. Project commissioning	Public & Private	1. State provides estates & funding; 2. Private investment; 3. Public purchasing 4. Direct purchasing.	1. state influences over projects; 2. High competition	Four districts in Shanghai
Pine Tree	Project commissioning	Private	1. Public purchasing 2. Direct purchasing		Six districts in Shanghai; many projects in Beijing

*My fieldwork recruitment process & state-market power relation*

The recruitment of interviewees of my fieldwork shows that care agencies in the free market model have more independence and a stronger voice in their relationships with local governments. The fieldwork data shows that owners and managers of large for-profit home care agencies have more negotiation experiences with government officials, rather than following administrative instructions as local providers normally do. According to the interview data, the relationship between care providers and local governments is relatively more equal in the free market model than in the other two models. For example, I interviewed one marketing manager in “Loving Care”, who introduced a government official at the sub-district level with working connections with this large for-profit care agency. It was a rare form of snowballing in my recruitment, which failed in many cases when I asked care providers to introduce government officials to participate in my research.

Considering the inspection and monitoring of care service delivery in the free market model, it is common that the “social organisation service centre” at the district level employs a third party to inspect the performance of care agencies and to submit inspection reports to local governments bi-annually or quarterly. At the same time, local government officials at the sub-district and the community levels also communicate with social service agencies to arrange emerging requirements of local governments or service users, as well as take action when problems (e.g. complaints from older people) are reported during the project implementation or care delivery process. Chapter 7 will discuss the accountability of the state in the care field and the monitoring processes in greater depth.

Even though care providers in the free market model have more independence and less control from the state, most owners and managers of large for-profit agencies argued that they still count heavily on policy and financial support from the state to establish the care market. These interviewees suggested that care providers prefer to compete in a quasi-market with reasonable interference and regulation from the state, instead of a completely open and free market.

“Care agencies like us wish to fill the care needs, but care needs of the larger group have not shown in the market yet. The state ought to guide the expression of care needs of older people in the market, operate trials, and boost the consumption.”

Le, executive of a care agency

“The government should provide guiding prices for care services.”

Chao, deputy of a care agency

The interview data show an interesting phenomenon of the competition for home care contracts: some care service schemes would bring no profits to care agencies, which was a consensus among care providers, but plenty of care agencies still tried to compete for the bidding of those contracts. The more influential power in the home care sector and prospective profit were suggested to explain why care providers actively expand their service coverage without immediate profits attached. Some providers argued that they bid for these projects with little profit as an investment strategy in the home care field based on the positive prediction of potential profits. Meanwhile, a few care providers suggested that it is a vicious competition applied by large agencies who have abundant assets to kick out smaller agencies, because local agencies have no economic backup to afford the risk of providing services without immediate profits.

“The market is very active. Capital always goes in advance. In my opinion, the current care market can be described as ‘all conquerors chase the same benefit’: agencies try to grab a larger share of the care market to expand their coverage, but they consider less about what to do in care delivery. There are plenty of private care providers, but only a few of them are good and responsible. The share in the market is connected to the influence level in the care industry. Currently, there are no generalised standards in the field of care for older people. The influence level of each care agency will surely be important in making regulations, training, and every aspect of the development of this field.”

Zhan, government official at the sub-district level

#### *Processes and reasons to adopt the model*

The fieldwork data show that Pudong District is one of the local governments who have more interest in choosing the free market model. This section illustrates the processes and rationale of the construction of the free market model from the local government perspective with examples of Pudong. As the front line of the development of the care market in Shanghai, Pudong District has set up the central bidding platform to contract out projects in the field of social welfare since 2010, which was the first among all districts in Shanghai. The power of

commissioning and monitoring is partly transferred from sub-district governments to the distinct department at the district level (i.e. social organisation service centre). Financial transfers from the state to care providers are also organised by the social organisation service centre. The separation of the need side (sub-district governments) and the contracting out and monitoring side (bidding platform in the district government) promotes the standardisation of the commissioning procedure. The following quotations demonstrate the key processes of how care service projects get contracted out in practice, from the perspectives of government officials and care providers, respectively.

“In our *jiedao* (sub-district), the commissioning of projects for public services are all organised by one office in Pudong District government, the social organisation service centre. This office gathers our requirements for each welfare project; advertises and contacts social service agencies; and posts bidding information on the central platform of Pudong District. If private providers get interested in the bidding, they will tender for it and attend the bid evaluation panel (organised by social organisation service centre).”

Wei, government official at the sub-district level

“Most large-scale care schemes are posted on the bidding platform, so as to show the equity to all agencies. Usually, the first stage is: social service agencies get the information about government plans to establish or contract out agencies or projects in one sub-district. Then, providers are involved in the process through the bidding. We compete in the bidding process with proposals based on the institutional capacity, advantages, and the suitability to projects.”

Fu, executive of a care agency

According to interviews with sub-district government officials in Pudong District, the central bidding platform was not a compulsory choice for sub-district governments. Sub-district authorities can contract out home care service projects by themselves (e.g. the limited competition model case exemplified in 6.2.2), while transferring to the central bidding platform is increasingly applied by different sub-district governments.

“Our *jiedao* (sub-district) has transferred all contracting out schemes to Pudong central platform. Some *jiedao* post the bidding information by themselves. We can directly post the commissioning information. This is different operation choice made by different sub-districts or districts.”

Zhan, government official at the sub-district level

Both positive and negative feedback on the free market model emerged from the interview data. As discussed above, efficiency instead of local or personal preferences is the priority in



the bidding process conducted by a central department for the whole district. Some local government officials and care providers agreed that the free market model show merits in the openness and fewer distractions from the local level. Meanwhile, another group of interviewees criticised that the phenomenon that increasing biddings are won by large for-profit providers in the free market model leads to the inequality in the care market (see Chapter 7). Local governments were advised to provide more support to those smaller agencies, which was explained as a reason by some government officials to apply the limited competition model and the state-controlled model.

“The increasing percentage of contracting out to large for-profit companies will make the competition environment unequal for smaller agencies, because large for-profit companies have more professional staff working on writing reports, which does not mean they can really do better in practice, and their increasing experiences of winning bidding projects across the city would make their background information better-looking than smaller local providers. This situation would trap smaller agencies in a disadvantaged position in the competition.”

Yue, executive of a care agency

### *Conclusion*

Processes and strategies of the marketisation of care discussed in this chapter show that care for older people in urban China is changing from the monopolistic state-based provision to a quasi-market, in which social service agencies compete for public contracts, consumers purchase care services with vouchers and subsidies, and agents represent consumers in the care market. Characteristics of the quasi-market are coordinated with processes of the marketisation of care. This chapter has elaborated two processes of the marketisation of care applied in Shanghai: contracting out care schemes, and financial support provided by the state to care providers and service users.

Based on the empirical data, I have identified three quasi-market models, namely the state-controlled model, the limited competition model, and the free market model (see Table 6.5). Each model is shaped by different contracting out strategies, financial support methods, hierarchies of power in the care market, and how it influences the state-market relations in turn. Different commissioning and funding strategies are employed by each local authority (governments at the sub-district level in Shanghai). As illustrated for each quasi-market

model, processes of the marketisation of care are applied to different levels of competition and government control. Influenced by the rationale behind the decision-making, the adoption of each model reflects different state-market relations.

*Table 6.5 Three models of the quasi-market in Shanghai*

<b>Models</b>	<b>Competition</b>	<b>State control</b>	<b>Government priorities</b>	<b>Contracting out methods</b>	<b>Commonly involved providers</b>
<b>State-controlled model</b>	Low	High	Local preferences	Pre-determined one agency	Local agencies
<b>Limited competition model</b>	Medium	Medium	Comparisons & combined considerations	Several chosen agencies	Diverse types of agencies
<b>Free market model</b>	High	Low	Efficiency	Open bidding	large for-profit agencies

This chapter has explored characteristics attached to each quasi-market model. Convergences and diversities of strategies jointly show a distinct process of the marketisation of care in urban China. As the marketisation of care for older people is developing at a rapid path, different outcomes come along the process. Based on empirical data from the fieldwork in Shanghai, Chapter 7 will illustrate distinct outcomes that emerge during the process of marketisation of home care in urban China.

## Chapter 7 Outcomes of the Marketisation of Home Care in Urban China

---

### *Introduction*

The marketisation of home care in urban China has developed rapidly in a compressed period. Home care has been suggested as the preferred care arrangement approach for the state and older people and their families (see Chapter 5), along with different quasi-market models emerging in the field of care for older people in recent years (see Chapter 6). Yet, the empirical and documentary data suggest that the care market is still an underdeveloped sector in China. This chapter explores impacts of the marketisation process in the home care field. Outcomes of the marketisation of home care are analysed through thematic topics in this chapter: the first section investigates the disputes on efficiency, competition, and for-profit motivations of care providers; the second section explores the outcomes in terms of care quality and the empowerment of service users; and the third section explores how the regulatory system is building and the embedded problems in the framework.

### *7.1 Unequal Competition, Care Labour Force & For-Profit Motives*

This section begins with an exploration of the changes of supply and demand in the care market and the competition between care providers. It then analyses the composition of the care labour force and emerging challenges in the recruitment, retention and training of care workers. The disputes and understandings of for-profit motivations of care providers are discussed in the third section.

#### *7.1.1 Increasing but unequal competition in the market*

The fieldwork data show that the supply of care services in the market has been significantly increasing in Shanghai since 2000. Most interviewees had an optimistic viewpoint that the development of the care market is beneficial to address the care provision deficit. The growth on the supply side of care provision helps fulfil the care demands of older people as well as promotes the competition between care providers.

“At the supply side, the number of home care providers increases every year. At the same time, the coverage of agencies is expanding. For example, our agency started providing services in one district in 2006; now, our services cover a few districts across Shanghai. The service supply has soared in this decade.”

Wang, care manager

Even though the supply of care services in the care market is increasing, it was argued by interviewees that the care service demands of older people are still far from satisfactory. For example, Jiao, a government official at the sub-district level, argued that *“the biggest problem in practice is the imbalance between supply and demand in the care market. It is very difficult to reduce this gap.”* Based on the analysis of documentary and empirical data, the rationale behind the imbalance between the supply and the demand in the care market can be categorised to: the large population of older people and high level of care demands, various requirements and preferences of older people, shortage of providers, and preferences of some providers for developing high-end services to chase up profits instead of expanding basic services to a bigger group with less profit attached.

“The supply cannot match the care demand. There are various kinds of care requirements of older people, but the supply is limited in types, standards, and amount. Some older people need special services or mental support, which are not available in the market.”

Wei, government official at the sub-district level

“Some providers only target work for high-end services, rather than expanding service supply to the public... because high-end care provision is a higher profit sector than providing basic care services.”

Liang, care manager

Although the supply side of care provision is not abundant, the willingness of purchasing services of the current old-old cohort is generally low in China (see Chapter 5), which leads to lower profit prospects in the care field. A few care providers argued that the shortage of the provision supply in the care market is because of the lack of attraction for care providers (e.g. people’s willingness to purchase, profits). They suggested that the potential development of the supply can be arranged as soon as care demands of older people can be expressed as purchase behaviours in the market.

“More and more care enterprises get into the field of care provision. But I have not noticed any rapid increase of purchases in the market.”

Xin, deputy of a care agency

The increase in the supply of care provision generally motivates the competition level in the care market in Shanghai. Chapter 6 has analysed different levels of competition in three models of the quasi-market. Some interviewees argued that the competition between care providers leads to the better quality of services and more systematic development of the care market. The involvement of independent care agencies challenges the old low-level competition care provision. For example, several managers from different care agencies criticised that some care agencies keep providing the same services without improving the quality or fulfilling individual needs of consumers, which would be weeded out in the competitive market.

“There is competition and fights between social enterprises. Agencies can learn from each other and gain complementary advantages through the competition. The positive competition will lead to the systematic development of the care market, which would be beneficial to all participants.”

Zheng, marketing manager of a care agency

However, the interview data show a consensus that the competition is not fully open or equal to all participants in the care market. First, referring to the admittance into the care market, financial support to the care service sector attracts diverse types of providers to get into the home care field, whose motivations and behaviours are different. Not all social service agencies are equipped with the knowledge and experience in care provision. For example, companies who used to provide care equipment (e.g. wheelchair, security alarms, and mobile phones) or insurance services (targeting older people) are trying to enter the care service sector when they noticed the potential profits in this field. Lacking experience in the care provision field, some new care agencies choose to cooperate with existing care providers, while others make efforts to establish new care agencies with funding transferred from other departments of their companies (e.g. technology, real estates).

“In recent years, we have met several cooperative partners: companies in real estate, insurance, medical treatment, machines, and so on. All these groups pay attention to the industry of care for older people. Some of them asked to cooperate with us to set up their service network. These companies usually have good financial status to invest in the care provision and finance fields.”

Xie, marketing manager of a care agency

Second, the competition is unequal for care providers in different quasi-market models, which relies heavily on the choices of local governments. Some interviewees were worried whether the competition could be equal for providers, especially for the state-paid care schemes. As discussed in Chapter 6, local authorities (LAs) manage competition in the care market by applying different contracting-out processes and oversee providers' performances throughout the bidding, delivery, and monitoring process. Decisions of LAs on which types of care providers could take state-paid care contracts heavily influence the competition model in the quasi-market. The information about contracting out of care projects is not equally available to all providers in each quasi-market model.

Chapter 6 has described how the state determines and manages different competition levels in the quasi-market with specific case studies. First, low-level competition is involved in the state-controlled model in which LAs usually only contact pre-determined local care providers, with consideration to protect local agencies, facilitate local employment, and get higher control over the care market. Second, the limited competition model involves medium-level competition, where different types of care agencies are included for comparison and competition based on the contracting-out criteria determined by LAs. Third, in the free market model, the open bidding process applied by the central bidding platform embraces high-level competition, where large for-profit agencies win the home care project biddings more frequently than smaller care providers.

According to the fieldwork data, there are no unified rules on how to contract out care schemes to social service agencies at the city level in Shanghai. Some interviewees argued that "relationship partners", those who have personal connections with local government officials (e.g. family members, friends, anyone with economic benefits involved), create disorder in the competition between care providers. A few owners and managers of care agencies criticised that "relationship partners" take advantage of their personal connections with government officials in the bidding process, which is an obstacle for other social service agencies without the government background.

"In the process when the *jiedao* or community purchases services with public funding, a number of 'relationship partners' get involved. The majority of 'relationship partners'

were people who used to work in the government or have families working in the government. Services of these agencies were of low quality and with little competition in the market.”

Yang, owner of a care agency

As shown by the fieldwork data, some home care agencies were designed by specific jurisdictions and only work for these areas. For example, a family-run home care agency in Pudong District was operated by a retired government official in one local jurisdiction. This agency only takes state-paid care schemes for older people in one sub-district where its owner worked before. According to the legal framework in China (see Section 7.5), it is forbidden for current government officials to do business or gain benefits from their practice, but there are no restrictions for retired officials. In this context, the establishment and operation of this agency still act within the law. Wei, a government official at the sub-district level, argued that this retired government official has good knowledge of the community and working connections with residents, so it is better to contract out projects to this agency whose background was known and trusted by the government. Nevertheless, some government officials and providers have noticed negative impacts of the unequal conditions prompted by local governments on the order of the care market:

“It is close to a ‘black box’ operation. Some agencies who have a government background received an extra ‘push’ from the local governments. This push can be covert or overt. These agencies get contracts, but they may not be the optimal choice. The order of the care market is disrupted by the ‘black box’ decision.”

Li, government official at the sub-district level

Yet, with the legal framework gradually getting stricter and more open, “black box” decisions with personal connections or benefits relationships have been decreasing in recent years, especially in large cities like Shanghai. Government officials argued that all public employees need to be more cautious about their behaviours when the state constantly takes action against corruption, which makes the competition environment more equal for most care providers. The rapidly increasing number of care agencies in turn gives more choices to local governments and inevitably pushes them to compare and involve more providers in the competition.

“The situation of ‘relationship partners’ has been slowly improving in recent years, especially after 2010. Shanghai government released the registration of social organisations from 2014, which encouraged plenty of social service agencies to rush into the field to compete for public contracts.”

Yang, owner of a care agency

Considering the competition between providers based on their sizes, large for-profit agencies generally act more aggressively in the care market in Shanghai, especially when local governments choose the free market model (see Chapter 6). The interview data suggest that most home care agencies in Shanghai were running with deficits. Motivations of providers are seeking a larger share of potential profits and potential influences in this field, with the belief that there will be profits in the near future. In this context, large for-profit agency chains have a stronger economic background to wait for a longer period for potential profits in the care market.

Besides, care agencies in varied sizes have different levels of influential power when they communicate or negotiate with local authorities. As in different models of the quasi-market discussed in Chapter 6, the preferences of local governments have impacts on the kind of care agencies being chosen for the state-paid services in each jurisdiction. Even though some local governments insist on supporting local providers to apply the state-controlled model and the limited competition model, the number of authorities who join the open bidding system has significantly increased in recent years. In this context, some care providers (especially those of a smaller size) have been kicked out from the care market or are close to going bankrupt.

#### 7.1.2 Care labour force: recruitment, retention and training

Many care providers and local government officials argued that the shortage of the care labour force is one of the most challenging obstacles for the expansion of care supply and the sustainable development of the care market. Owners and managers of care agencies expressed their concerns on difficulties in recruiting and retaining care workers, which shows the high job mobility of care workers (for both home care and residential care) in China (Liu and Zhuang, 2012; Xiao and Chen, 2013).

“The difficulty of recruiting care workers is widespread across private home care agencies, care homes, and for individual older people.”



## Chapter 7

### Outcomes of the Marketisation of Home Care in Urban China

Ying, community official

“I wish that more people would like to come to purchase services from our agency; however, we are short of care workers to provide more services.”

Liang, care manager

As discussed in Chapter 6, “40/50” laid-off workers used to be a substantial group in delivering care services across many cities in China. However, the “40/50” policy was designed to help laid-off workers (specifically due to SOE reforms in the 1990s and the 2000s) re-enter the labour market, which no longer recruits new members after the mass lay-offs stopped. With this group dramatically decreasing in recent years due to retirement, there emerges a gap between the demand and supply of the care labour market. The decrease in the “40/50” group leads to a problem for care providers to remain in the service delivery as before, especially for community care agencies, where most employees belong to the “40/50” group. As exemplified in Chapter 6, this is one reason for some local authorities to involve more independent providers in care provision.

“We meet a lot of problems in recruiting care workers. There are currently 28 care workers in this public care agency, all belonging to the 40/50 group. The 40/50 group was designed for the unemployed group in the 1990s, which does not enrol new workers anymore. There are people who want to get into the 40/50 group, but it is not allowed now. However, we do need more care workers. It is a dilemma that we cannot increase the 40/50 group. The 40/50 group is ‘fading away’ as they reach retirement age.”

Zhou, executive of a community care agency

Considering the composition of the care labour, the fieldwork data show that the majority of care workers across different care institutions in Shanghai are female rural-urban migrants who are in their 40s and 50s. Based on statistical and empirical data collected in Shanghai, the care labour market for older people in urban China relies heavily on migrant care workers. According to the Shanghai Statistical Yearbook (2015), among the 24,150,000 population in Shanghai, 13,410,000 are working population (55.5% of the whole population). Within the working population, there are 6,350,000 local citizens (44% local people are working) and 7,060,000 migrants (72% migrants are working). 77% of workers in the service sector are migrants from rural areas. There is no statistical data on the specific percentage of migrants who are working in the field of care for older people, yet, all participants in my fieldwork agreed that the majority of care workers in Shanghai are rural migrants.

“Care workers in those two social service agencies are all migrants recruited from the market.”

Zhou, executive in a community care agency

“I don’t know the exact composition of care workers, but absolutely the majority of them are migrants. Middle-aged female rural migrants.”

Chao, deputy of a care agency

“When this agency was established, there was one local care worker... Then, he got family members requesting care at home, so he quit later. Care workers employed in our agency are all migrants now.”

Wang, care manager

The care labour recruitment and retention in Shanghai encountered similar obstacles as proposed in many other countries, such as low income, heavy workload, unrespectable social status, and other practical difficulties (e.g. mental stress, keeping service users satisfied). During my fieldwork, these factors were suggested by many interviewees as reasons for why the recruitment of care workers encounters challenges in China. In terms of the situation that younger generations and local citizens (Shanghainese in my study) have little willingness to participate in the care labour market, unattractive income and low social respect for care workers were identified as two major reasons by care providers.

“Improving social respect for this job (care worker) is urgent. Without an improvement of the social status of care workers, it is difficult to attract people to enter this field, especially for younger generations. Current female care workers who are in their 40s and 50s are not very picky about the job, but it will not be the same for the next generation who were born under the one-child policy. They are very picky about care jobs, while barely know how to provide care to others. So, in the near future, it will be more difficult to recruit care workers, even if you provide a good salary.”

Yue, executive of a care agency

“We do not have preferences to employ migrants, instead, it is because we cannot recruit local care workers. Shanghainese do not want to take this job. There are concerns about working as care workers: income and social respects. This occupation has not received enough respects. Low respect is the biggest obstacle, bigger than the income. For example, some enterprises do not give high salaries, but their workers are well-respected. Thus, the income is the basis; respect is more important.”

Ju, executive of a care agency

As migrants currently are the mainstream in the care labour market, most care providers were worried about new population control policies issued by the Shanghai government in 2015, which might lead to more difficulties in the recruitment of (migrant) care workers. The

*“Thirteenth Five-year Plan of Shanghai”* (Shanghai Municipal Government, 2016b) points out that the population in Shanghai, which was more than 24 million in 2016, shall be controlled at 25 million by 2020. Considering the composition of the population in Shanghai, there are two groups: first, the registered citizens who have Shanghai *“hukou”*, second, migrants who live in Shanghai long-term without Shanghai citizenship. In 2015, the Shanghai citizenship population was 14,340,000, while the number of migrants was 9,816,500. In fact, the citizen population in Shanghai has kept decreasing since 1993. Thus, the population control project of the Shanghai government targets the number of migrants. In this policy context, difficulties in the recruitment of care workers will increase in Shanghai. Yet, other large cities (e.g. Guangzhou, Shenzhen) who welcome migrant workers with supporting policies, would attract a larger migrant inflow in this context.

In terms of how to address the problem of care worker recruitment and retention, owners and managers of care agencies had suggestions that request support from the state: increasing salary, providing social benefits, and improving the social status of care workers. Most local government officials and care providers agreed that subsidies for care workers should be increased by the state. Besides, some interviewees suggested the necessity to set up a more standardised payment system for employees.

“I hope the state could draw up some policies to improve the social status of care workers. For example, it would be better if care workers can get access to social security or health insurance benefits based on their care work experiences.”

Chao, deputy of a care agency

“The subsidies for care workers is ¥100 RMB (£11) per month, which is far too low. If the state increases subsidies for care workers, we may attract more people to get into the care sector or retain care workers, especially for younger care workers, not only the 40/50 group. If only relying on the development of profit of agencies, salary for care workers cannot get to higher levels. Then there will not be people who would want to join us. Money is the basic thing for care workers; without good payment, they cannot provide services to older people with good quality and a smile.”

Liang, care manager

Some government officials suggested that the allocation of subsidies to care workers is the first step to improve the income and social respect of care workers. However, the “care worker subsidy” provided by the state acts as another funding source to care providers. According to the fieldwork data, care worker subsidies are not directly allocated to care

workers. Instead, home care providers receive funding based on the number of care workers employed in each agency. Care providers have the autonomy to allocate the care worker subsidies, without further monitoring from the state. In this context, how the care worker subsidies are used is kept as hidden information by providers. Thus, the care worker subsidy is one funding source to providers in practice, rather than a realistic subsidy to care workers as stated in policy rhetoric.

According to interviewees in most care agencies involved in my study, the “care worker subsidy” was put in the salary to care workers. Yet, payment slips for care workers show no information about the public subsidies, while the payment is exclusively based on their working hours in each month. Care providers agreed that care workers generally have no idea about the “care worker subsidy” allocated by the state. The quote below shows the explanation from care providers on why they keep the care worker subsidy.

“Care workers’ salary is a fixed number, but the income of our agency is not stable. We (care providers) do not directly add the ‘care worker subsidy’ to care workers’ income. We use the ‘care worker subsidy’ to balance our income and expenditure. So, we can keep the same salary payment level even if the agency is not running well... we keep this income to use when the going gets tough.”

Wang, care manager

Nevertheless, it is a fact that the “care worker subsidy” has not been received by its targeted group. A few government officials argued that care workers have no idea about how much of the subsidies they are entitled to from the state, while the public is unaware that the state allocates job subsidies to care workers. In this context, these government officials suggested that the payment methods of “care worker subsidy” ought to be changed to ensure that care workers receive benefits paid by the state. Monitoring on the allocation of subsidies was proposed as a manageable solution in the first step.

At the same time, it was argued that care workers are not covered by working insurance (e.g. pensions, health insurance), which is another important reason for the high mobility of this position. Care workers do not want to get their hands tied in one place without relevant benefits in the job contract. In my fieldwork, Xin, a deputy of a home care agency, argued that the mobility rate decreased in her care agency after they provided work insurance to care

workers who promised to provide home care services under contracts with this agency in the longer term (one year or longer). Xin's agency takes occupational benefits as an advantage to recruit and retain care workers. Yet, this case is an exception in my fieldwork, as the basic work insurance is not popular among home care agencies in Shanghai. Care providers criticised that insurance products for care workers are limited in the types and protection levels, while the price is too expensive for care providers. Risks during care delivery allocate pressure on care workers and providers, which in turn make care workers more stressful and restrict the types of services they would like to provide.

"We only provide basic services. We have no protection for any potential bad possibilities. For example, bathing is a bit risky. Older people might fall; care workers cannot afford the medical treatment; then the agency has to pay a lot. It is not worth taking risks."

Hua, care manager

In addition to the recruitment and retention of care workers, there were also concerns among interviewees about training and vocational support for care workers, which was suggested to be tightly connected to care quality. A few care providers argued that they had paid attention to the importance of training on practice techniques and stress control of care workers. Specifically, the mental health of care workers was emphasised by care managers. They indicated that the heavy workload and relationships between care workers and older people bring plenty of stress for care workers. Regarding the funding source for job training, the Shanghai government started to allocate subsidies to care agencies if their care workers attend training programmes and pass the qualification exams in 2014. Yet, the certified care workers only represent a relatively small percentage in the care labour group.

"The state allocates financial support for service delivery, but not for the team building of care workers. It is necessary to build up high-quality care worker groups."

Xin, deputy of a care agency

"Education and training for care workers are important. The general competence level of care workers is relatively low. It will turn out to be a futile attempt without improving personnel competence."

Liang, care manager

"Care workers have heavy pressure for daily duty as well as difficulties to satisfy their clients (older people). Mental support for care workers is very important."

Sun, care manager

7.1.3 Disputes on the for-profit motivations of care providers

According to the analysis of documentary and fieldwork data, most care agencies in China are registered as social service agencies, without being categorised into for-profit or not-for-profit organisations. The state controls the registration of home care agency licenses as “social service agency” to exclude for-profit agencies gaining public subsidies; however, the registration department issues licenses to organisations without any background check. The fieldwork data suggest that for-profit and not-for-profit care providers co-exist in the care market in China. Both types of care agencies were recruited in my fieldwork. There was a common view among interviewees that all care agencies need to gain profit for the sustainability of the business, while their motivations and profit targets are different.

Owners and managers of care agencies define the nature of organisations by themselves, which is not a reliable value for analysis. Interviewees who defined their agencies as for-profit ones were relatively more ambitious about chasing profits in the care market, but it might be because the ambitious group tends to admit for-profit motives. It is not easy to distinguish whether a care provider is for-profit or not-for-profit in China. For example, an executive of one social service organisation argued that this agency aimed to be an independent marketised agency; however, care agencies in Shanghai were not allowed to be registered as an enterprise organisation. They had to choose the category of the not-for-profit agency for the business license, but the agency does run for profit.

Meanwhile, some providers entered the care market to chase financial profits, but they claimed that they are not-for-profit agencies to gain more support from the state and show better impressions to service users. Owners and managers of these agencies have clear for-profit motivations, but they do not publicly claim it. According to interviews with care providers, some agencies exploit loopholes in the current legal framework to establish new branches and to expand service coverage. As the quote below exemplified, care providers argued that they take “grey” (rather than illegal) actions to avoid the situation of being trapped in the unreasonable registration system.

“If the registration type of this agency can be changed from ‘People-run Non-enterprise’ to ‘Social Enterprise’, I would be able to open branches at different locations. But, I will

lose a large amount of funding from the state, because the state barely purchases care services from social enterprises, but the 'People-Run Non-Enterprise' is not allowed to have branches. It is a dilemma to me... I have to choose a weird developing model: establishing 'branches' in other areas with new names, while all registered as 'People-Run Non-Enterprise'."

Qing, owner of a care agency

Care providers have different interpretations of the nature of their organisations. During my fieldwork in Shanghai, I found the inconsistency of understanding about the authentic type of care agency between government officials and care providers or even among the management group in the same agency. For instance, I interviewed one care manager and one marketing manager in the care agency "Friendship". The quotations below show their different ideas about the for-profit or not-for-profit motivations for this agency.

"'Friendship' is a not-for-profit organisation; we do not have the idea of making profits. We only need to maintain the daily operation, enhance the service quality, and try to provide services to a bigger number of older people...Our aim is to develop better services, to promote the standardised development of this field. We just need money to maintain the agency to achieve the aim."

Wang, care manager

"This care agency is called a not-for-profit organisation, but actually, it is a market enterprise. It is difficult to explain the real nature of this agency. This management mode was called not-for-profit because of the restrictions of government policies. To my knowledge, it is surely for-profit agency. But we can only get the 'people-run non-enterprise organisation' license, instead of an independent enterprise license. If we want to gain trust from older people and keep a good relationship with the state, it is better for us to claim that we are not-for-profit."

Xie, marketing manager in a care agency

Some interviewees (especially government officials, also a few care agency managers) criticised the behaviours of care providers in chasing profit in the care field. They suggested that the increasing financial investment and policy support from the state are the main attractions for most providers getting involved in the care market. They were worried about the quality of service delivery due to some unprofessional providers getting into the care field only for profit rather than promoting the welfare of older people. For example, some interviewees suggested that the increasing number of care agencies does not necessarily lead to better quality of care services for older people, especially when the for-profit motive of care agencies overcomes the idea to promote welfare:

“In the care industry, there are many participants. Currently, various types of organisations are fighting to take part in the field of care for older people. However, the increasing number of participants may not lead to a better market... Providing good services is a slow process, which involves mutual respect (between all participants), not only caring about money.”

Yue, executive of a care agency

“I wish home care providers can allocate more attention to the public welfare, rather than focusing on profit-driven objectives. Then they can cover a bigger group of older people.”

Lei, community official

On the contrary, some care providers argued that for-profit motives and behaviours are common to all providers in the care market, which do not necessarily get connected to the low-quality service or unfriendly care relationships. They explained that some care agencies who entered the provision field earlier named themselves “not-for-profit” while apply the “for-profit” concept to “label” new competitors. Some government officials also recognised the necessity for care providers to gain profits in the care field, which was considered the basic attraction to involve independent participants in the care market and to promote their competition. Besides, there were viewpoints that care quality, care delivery process, and service fees are more important than arguing to differentiate “for-profit” or “not-for-profit” motivations.

“There are good and bad private or for-profit care agencies. Some can successfully last for a long time, while others fail in a short time. For example, my mum is living in a private care home, which provides high-quality services and management...In my work and personal experience, no matter home care agencies or care homes, attitudes towards consumers of for-profit organisations are even better than public organisations.”

Lei, community official

## *7.2 Care Quality and Empowerment for Older People*

In the context of increasing supply and competition in the care market, it is questionable whether older people get access to care with better quality, whether they are equipped with more choices and equally empowered to make decisions in care arrangements. This section investigates outcomes in the aspects of care quality and choices for older people in relation to state-paid schemes and direct purchases.



7.2.1 Under-emphasised care quality

The interview data show that the care quality has not followed the path of increasing service supply in the market, which has gained less attention from the state and service users when compared with the availability and cost of services. Owners and managers of home care agencies held a common view that the state and older people and their families are currently more concerned about the budget control than care quality. It was also a common view among different groups of interviewees that the quality of care services is generally low at the current stage. For example, Yue, an executive of a social work care agency, argued that *“the quantity of care service is increasing, but the quality remains very low.”*

Considering the reasons for the outcome of low-quality services, an overwhelming view from the interview data suggests that both direct purchasers (older people and their families) and public purchasers (local governments) seek cheaper costs and higher efficiency rather than better service quality. For direct purchasers and service users, the majority of older people give priorities to the lower price than the quality of care services when they make decisions.

*“The current older generation does not have enough purchasing power. They ask for the basic cheapest services without caring about service quality.”*

Jiao, government official at the sub-district level

Regarding public purchasers, the state shows little concern about care quality in the contracting out and evaluation processes. Instead, priorities are given to the budget control. “Cost control” was commonly suggested as one of the most important concerns for local authorities across Shanghai. Government officials and care providers indicated that local governments prefer to choose lower price services for state-paid home care projects with fewer concerns about quality. Based on the analysis of policy documents and the interview data, I apply Le Grand (1991)’s concepts to argue that the Chinese government pays more attention to the crude efficiency of “costs of care provision” instead of productive efficiency of “value for money”.

*“Considering the public purchasing, they (government officials) prefer to get the cheapest services. The governments want to purchase care services at the price of ¥20 or 30 RMB (£ 2.2 or £3.3) per hour, or even less. From our perspective, on one hand, we cater to their preferences, because we want to get access to more resources, such as the*

commissioning of care service projects in their jurisdictions and build up working relationship with governments. On the other hand, we must reduce costs of the services, for example, paying less on the labour, applying more technological services in care delivery. All agencies in the field of home care are experiencing this problem.”

Wang, care manager

Inevitably, expectations of the state on saving costs or expanding the group of benefit recipients do not always turn out as outcomes in practice. The initial low budget expectation might end up a waste of investment or more unexpected follow-up investment. Interviewees exemplified some schemes that had failed to achieve their primary objectives. Fang, a marketing manager, shared her viewpoints on a public project called “Star Plan Home for Older People”. The Star Plan was funded by the Ministry of Civil Affairs from 2001 to 2004 with ¥13.4 billion RMB (£1.47 billion) for the establishment of over 32,000 community activity centres (no care attached) for older people across the country; however, most of these agencies no longer existed while others were barely known to residents by 2016. After the MCA stopped investing in the project in 2005, some facilities of these day centres disappeared with no sign of old facilities; a few of them turned to high-end private care clubs; others were gradually abandoned with nobody operating or attending. Fang suggested that the reason for the failure of this project was the state focusing on the quantity of facilities without considering the genuine needs of the target group, provision quality, or the sustainability of projects.

“I conducted interviews in several *jiedaos* in Shanghai in 2012. At that time, when I asked residents and community officials about care projects for older people, they still proudly talked about the ‘Star Home’. Especially in old communities, they thought it was a good project for older residents to get an activity space. However, all of them are gone or abandoned. With a big fortune of more than 10 billion, isn’t it possible to do some sustainable care schemes, rather than a good-looking number of facilities increasing and then disappearing in a short period?”

Fang, marketing manager in a care agency

Furthermore, the interview data demonstrate that the voice of purchasers (individuals and the state) is increasingly being heard in the care market. Some interviewees argued that the home care market is “buyers-centred”, in which care providers try to fulfil the preferences of purchasers. In this context, care providers argued that they would be happy to provide high-quality services, as long as those are what purchasers want and reasonable prices are paid. Criticising the current situation that all state-paid services are at the same price, Mai, the

executive of a large for-profit care agency, suggested applying a multi-level pricing system based on different service standards (e.g. service items, experiences and performance of care workers). However, these proposals have not been considered by purchasers yet.

“The care service market gradually becomes a buyer’s market. Requirements for care services, care workers, and care quality are increasing. They (purchasers) surely wish to get the service at a reasonable price, following a standardised process, and with good quality.”

Xie, marketing manager in a care agency

Interviewees held different views on potential changes in purchasers’ preferences. On one hand, some care providers and government officials argued that older people and the state gradually turn to require higher-quality care provision. They suggested that care recipients and purchasers have turned to care more about the care quality and care relationship in recent years. According to their working experiences, there were service users critiquing and complaining about no quality guarantee on home care services, and for the situation that some basic kinds of care needs cannot be covered (e.g. night care for older people who are disabled or living alone). Hao, a sub-district government official, emphasised that the jurisdiction where he was working had started to pay attention to the feedback from older people: *“satisfaction level of service users is still low, which is an important problem for us to deal with.”*

On the other hand, another group of interviewees suggested that priorities on lower prices instead of better quality has not changed and will last for a while. The main reasons behind this argument focus on the insistence on living a thrifty life and preferences on savings than consumption for older people (see Chapter 5). Based on the analysis of different viewpoints, it is highlighted that first, the supply of care services in the market is increasing, but it still cannot cover the care needs in the ageing context; second, even though the service quality has not gained widespread attention yet, it is gradually becoming an important concern for individuals and the state.

#### 7.2.2 Inequality of choices for older people in the care market

Choices for older people slowly expand when the care market develops. Older people in Shanghai have been offered the choice to stay at home for care or to move to residential

institutions. However, choices on detailed home care services are insufficient and usually unequal for older people. As discussed in Chapter 5, direct purchasing is tightly related to family members' decisions and their economic background, while state-paid home care services are chosen by local governments in the contracting out process rather than a choice for service users (see Chapter 6). In this context, older people are generally not empowered to make free choices on what services they can have or purchase in the care market.

“The participation of home care providers gives more convenient choices to older people, especially when their economic background is not good enough to purchase long-term services at care homes.”

Lei, community official

Specifically, strict restrictions on choices are attached to state-paid care schemes. According to the interview data, purchasing decisions of state-paid services are made by local government officials, while direct service arrangements are designated by community officials or care providers on behalf of older people who are qualified for the state-paid care services. Local governments only offer choices within a small range of care providers (one agency in most cases) that have gotten the commissioning. In this context, older people can only choose to change care workers after getting approval from the agency or the local government, but it is not possible for them to swap to other care providers that are not chosen by local governments.

“Older people give feedback on care services. If they are not satisfied with services provided by one care worker, they can ask to replace another one for them.”

Zhan, government official at the sub-district level

Considering the reasons for allocating limited choices to older people, some interviewees argued that government officials work as agents on behalf of older people to make care arrangements. More specifically, a few interviewees suggested that many older people face challenges in making decisions in the care market, so local governments help them make a better choice. From the care provider's perspective, it was a common view among my interviewees that they follow local government orders for the state-paid services, based on an assumption that purchasers have more power than service users.

“In the open market, there are so many providers; older people are not equipped with experiences to distinguish the quality of each agency.”

Zheng, marketing manager in a care agency

In addition to state-paid services, the care market is open for older people to directly purchase services through private funding. According to the fieldwork data, the majority of older people have no financial support from the state to purchase care. Older people who would like to pay by themselves (without public support) can choose any provider based on their own will or their family's will. In direct purchasing cases, the economic background of older people is an influential factor. The inequality between groups of older people and their families (see Chapter 5) was evidently observed in those direct purchasing cases.

“Most direct purchasing is made by older people who have to purchase care because of the health conditions or other problems that their families cannot deal with, or by very rich groups.”

Jian, care manager

The interview data show that only a small group of older people who have a large fortune or enormous financial support from their children are able to make free purchasing choices in the open market, while it is a difficult decision for the majority of older people. Nevertheless, a large number of service users are the mid-income group who have challenges in daily life and are short of informal care. In this case, older people and their families try to achieve the basic and cheapest services in the market. Thus, choices in high-quality care services are restricted to a small number of the high-income group. One care provider argued that those high-end care agencies targeted to provide services to rich consumers have gained more profits than other providers, which is attractive to capital investment.

“The home care market covers many aspects, not only home care services, daily life support, rehabilitation, but also mental health support, physical exercise, travelling, and other high-end consumptions. I know one Sino-Japanese joint venture agency in Chuansha (in Pudong District), which applies the management model and service methods from Japan to provide high-end care in Shanghai. Their service fees are between ¥20,000 to 25,000 RMB (£2,200 to £2,750) per month. Their employees are all qualified nutritionists, physiotherapists, or professional care workers with education background above college level. If there are enough needs and profits, the market will follow up soon.”

Liang, care manager

Furthermore, geographical differences reflected in the quasi-market of care in urban China were suggested to be relevant to the inequality between older people. Based on the fieldwork data, the autonomy of local governments on commissioning and regulating care service projects leads to geographical differences in each jurisdiction (see Chapter 6). In addition to differences within Shanghai, the regional disparities in China are even more noticeable. A few local government officials argued that the geographical differences on the economic background and public support lead to increasing inequality between older people living in different places.

“There are huge disparities in different local jurisdictions. For Shanghai, it is generally OK in the field of care for older people. Some governments in other areas do not pay attention to the care field. They always say it is not their accountability scope, or they lied that they had invested, but where is the money being allocated?”

Wei, government official at the sub-district level

### *7.3 Deficient Regulatory System*

It is a key role for the state to regulate and inspect the care market and to protect older people's rights, which is debatable in terms of the performance of the Chinese government in the marketisation context. This section explores the regulatory system of care for older people in multiple aspects, including the legal framework, the accountability of the state, and the regulatory performance.

#### *7.3.1 Legal framework*

Considering the regulatory system of the Chinese home care market, the state sets legal requirements relating to home care providers and specifies their service domain. There are different regulatory functions in the care field, such as licensing and registration of care agencies, service assessment and inspection (mainly for state-paid schemes), and monitoring of contracting out projects.

The data collected from the fieldwork suggest that the state in China has strong control over the care market but lacks practical rules and regulations from a legitimacy perspective. Most care providers argued that current legal requirements in the care field are no more than pro forma paperwork. For example, as discussed in Section 7.1.3, the licencing system for social

service agency registration does not reflect the true nature of care providers. By means of controlling the licences application, regulatory authorities aim to restrict for-profit activities of social service agencies. Yet, both interviewee groups of local government officials and care providers suggested that regulatory rules on the licensing of home care agencies are not in accordance with care practice as well as not being strictly or systematically implemented by government administration.

Most of the care providers and local government officials who participated in my study argued that the national or geographical (e.g. Shanghai city level) regulatory framework is absent for home care provision, to which they believed the state should take swift actions to make the legal framework. As Le (an executive of a care agency) proposed, *“we urgently need order and guiding authorities in the care market.”*

“For the better development of the market, it is essential to set a supportive system with all-round rules, regulations, and policies.”

Xin, deputy of a care agency

To deal with these limitations of the legal framework, formulating laws and regulations was proposed by some local government officials and providers as the first step to prevent potentially illegal actions. For example, the phenomenon of the “black box” decision process and “relationship partner” deals (see Section 7.1) was strongly advised to prohibit in terms of regulatory laws and policies as well as in practice. Some care providers suggested that the positive competition in a well-regulated home care market without insider trading or unfair interventions from local governments is an optimal environment for participants, including care providers and service users.

“Setting up rules, regulations, laws, and lists of prohibited behaviours are the most important tasks for the state. ‘Absence of legal prohibition means freedom’. We (government) need to try our best to stop those leaks (of the legal framework), to tighten the fence, to draw up the legal range. Then, private providers can work in this regulated field. As long as it is a reasonable competition, more suitable players will survive in the care market.”

Zhan, government official at the sub-district level

Specifically, legal actions on setting up the “blacklist” or “negative list” to regulate the admittance to the care market was a strategy suggested by some interviewees to control over unequal competition and the involvement of unqualified agencies. A few care providers and local government officials criticised “black agencies”, who run the business without licences but directly advertise themselves to older people and their families. These “black” agencies usually offer services at a lower price (based on the fact of low cost: no tax payments, no registration fees, no long-term investment), which is attractive to some older people when the price is the top concern for them in making decisions for care service purchase.

However, the quality and sustainability of care services cannot be guaranteed since there is no inspection of these care providers at all. Older people are at a risk purchasing services or employing care workers through these uncertified agencies, while care workers in these agencies cannot get their rights protected either. Some “black agencies” are small-scale care agencies or staffing agencies who do not want to pay or cannot afford registration fees, taxes and other fees (which might emerge in any market and embrace risks inherent in the informal market, but not necessarily cause more negative outcomes to service users than registered providers), while some “black agencies” put older people and purchasers in great danger. Interviewees shared crimes or incidents from their jurisdictions about some “black agencies” maltreating service users or even stealing or conning money from older people, which were difficult to trace because these agencies and their employees were never registered.

“There are black agencies in the home care field, who have no licences, no qualifications. They advertise themselves with a board and a phone number. The state has not monitored these black agencies. Can you imagine that sometimes I can see a dozen black agencies in one community? Without cracking down on black agencies, legal providers are difficult to develop. These black agencies illegally grab the market and win the profits.”

Xin, deputy of a care agency

Many interviewees strongly argued that it is imperative to issue legal documents in inspecting the care market and to take legal action against badly-behaving providers or other participants, instead of only issuing registration paperwork. Some care providers also suggested constructing a public trust platform to present a blacklist of badly-behaved agencies. According to their arguments, older people usually have no more information about



one care provider except the experiences of their families, friends or neighbours. If local governments, older people and their families, and care providers can get access to the open information on the trust platform, it would help older people to make better choices and push care providers to do a better job.

### 7.3.2 Accountability of the state in the care market

According to the documentary and empirical data, macro regulatory roles (e.g. licensing, contracting out, procedure monitoring) are carried out by the central and municipal governments, while practical regulatory responsibilities are taken by local governments (e.g. sub-district governments in Shanghai). Based on my fieldwork data, the lines of accountability of the state in the care market seem similar in direct purchases by service users and state-paid care schemes, but the involvement of the state is much more active in state-paid schemes than direct purchasing.

The regulatory actions of the state generally deviate towards state-paid services, while direct purchases are mainly settled between care providers and service users (purchasers at the same time). Some local government officials argued that direct purchases with private funding are independent decisions made by older people and their families in the care market, during which the state has no responsibility or energy to take part in the process. Yet, many care providers argued that it is important for the state to improve the regulatory framework in the care market in general, especially for direct purchases. For example, some vicious “black agencies” are targeted to deceive direct purchasers, which calls for the state to act as an active regulator in the market.

On the accountability in state-paid schemes, after winning bids of home care schemes from sub-district governments, care providers get the list of service users from each community. The interview data show that the majority of state-paid service users are older people who are qualified to free home care based on the guidelines implemented by the Shanghai government, while a few sub-district governments allocate local funding into the care scheme to expand the coverage of home care services in their jurisdictions. Care providers keep close working connections with the community and sub-district governments for state-paid care schemes.

“The implementation and modification process of policies include: superior governments (central government and the city government in Shanghai) set up policies and plans; *jiedao* (sub-district) governments implement in practice and submit feedback to the superior; superior governments make modifications and expand good practice to other sub-district jurisdictions or drop out if they are not satisfied with trial results... For example, the ‘Assessment of Care Needs of Older People’ was set up in several chosen *jiedaos* at the first stage, then it got expanded to a whole district, and is now widely applied across Shanghai.”

Jiao, government official at the sub-district level

In terms of the accountability of the state over daily care work provided by social service agencies, the fieldwork data suggest that if older people are dissatisfied with services or care workers, they usually report to community officials as the first step. As discussed in Chapter 5, community officials would either contact care providers to deal with the complaint or report severe incidents to the sub-district government. If the sub-district government is unhappy about practice feedback, they may stop contracting out to the specific provider. The incident processing procedure shows the accountability of each position in the care delivery and the monitoring processes.

According to the fieldwork data, monitoring activities include daily inspection (usually conducted by community officials and occasionally by superior governments or external investigation organisations) and voluntary feedback reported by service users (older people and their families, sometimes volunteers as their agent). Specifically, community officials are entitled to routine monitoring responsibility for care delivery as the forearm of the government. The volunteer system in the community (see Chapter 5) helps older people in their daily lives and gives them emotional support, especially for those who are living alone. Community officials collect feedback from the front line and report to the welfare department in the sub-district government. Yet, as suggested by community officials that participated in my study, their workload was so heavy that they turned to collect feedback from volunteers or waited for older people and their families to report. Furthermore, managers in charge of welfare issues in sub-district governments have the power to contract out, suspend, renew, or terminate state-paid projects. In short, community officials are practitioners in the routine monitoring process, while sub-district executives are decision makers to contract out and oversee care provision projects.

The interview data also suggest that the accountability within the government is complex and implicit. On one hand, there are either overlapping or vacant roles between different departments. Both local government officials and care providers complained that they have difficulties finding the right place to contact when specific problems emerge in care practice. For example, in one case shared by Li (a government official at the sub-district level), an individual service user went to the sub-district government to report illegal behaviours of a care agency (breaking the one-year agreement before due date). The sub-district government had no power to investigate the care agency because it is neither registered nor based in this jurisdiction, so Li advised the resident to get to the Civil Affairs Bureau at the district level. However, the staff at CAB asked them to get to the Registration Office for Care Agencies or the Commercial Union, while government officials working at these two departments argued that dealing with care delivery conflicts is not their duty and asked consumers to get back to the CAB. Li argued that there are no clear boundaries between each department and government officials sometimes push enquirers to other departments in this context.

On the other hand, in some situations, with little inter-department communication, projects conducted by different departments might cover the same group of recipients. A few government officials in my study criticised the waste of public resources by repetitively allocating to the same group without investigating the genuine care needs of target groups, which is also a barrier in the policy implementation process (see Chapter 8).

“There are no specific departments dealing with issues in the field care for older people. For example, older people with disabilities could get social services supported by state-paid projects for disabled groups, which are different from general care services for older people under the Civil Affairs system. Services, rights, protections are different for each group among older people. There are overlapped parts for individuals in each group.”

Wei, government official at the sub-district level

Meanwhile, government officials at management level play an influential role in care policy and practice. As discussed in Chapter 6, government managers have impacts in shaping the quasi-market model in each sub-district in Shanghai. The decision-making hierarchy is still a top-down system that barely involves feedback from subordinates at the local level. The quotation below is an example shared by one sub-district government official on how he proposed two plans to his manager about the safety issue of older people who are living alone

at home. This interviewee argued that this sub-district had enough funding for each plan, but the leader rejected these suggestions without any discussion or explanation.

“For the safety problem, if one older person is not able to move but cannot afford to hire a care worker, what should be done? If they live without any carers, safety is a basic need, especially at night. We have community volunteer system in the daytime, but the safety problem cannot get solved...I submitted a proposal on the safety issue of 1756 older people who live alone in my jurisdiction. This group has high-level risks and dangers at night. For the worst situation, it won't be known even if they die at home. If the employment of care workers for the whole night is too expensive, I suggested applying the technical equipment of an infrared sensor for this group at their house (on the budget of local government). But my superior thought there is no meaning to this and rejected my proposals without discussion. Well, it is OK, I won't apply it.”

Hao, government official at the sub-district level

In this context, local government officials have suggestions on the institutional system for the decision-making process to be less complicated or monopolistic. They suggested that the policy-making process needs to take into account feedback from implementers (local government officials) and care practice (participants in the care market). The gap between policy-making and implementation will be discussed in depth in Chapter 8.

“Sometimes it depends on your luck. If the leader (of local government) is nice and happy to work on this issue, he says yes, then the work will be done. But, it is your luck... There should be a systematic process available for these proposals.”

Li, government official at the sub-district level

“If you have good proposals, you have to ask for agreements from lots of superiors. It then depends on the personality of the leader (to approve it or not), rather than the contents of the proposal.”

Chao, deputy of a care agency

### 7.3.3 Regulatory performance

Service monitoring was a key concern for government officials and care providers. For state-paid care schemes, it was suggested that inspection and surveillance enable the state to monitor whether care service projects are carried out in accordance with approved standards or expectations. The monitoring of care practice in urban China counts more heavily on outcomes and the quantity rather than the process and quality. In general, care quality and care relationship between care workers and older people are not well-monitored by the state or by care providers.

“The state always purchases services for a specific number of target groups without evaluating service quality. Care quality is different (worse) than our expectations.”

Jiao, government official at the sub-district level

The irresponsibility of care workers or care providers in the service delivery is a common topic raised by participants in my study. Based on the interview data, a common trick happening in state-paid service schemes is the fraud agreement between care workers and recipients on counting services without real provision (see the quotation below), which works against the contract set by the state and goes against the primary objectives of these schemes. To avoid these “illegal” behaviours, community officials occasionally inspect whether those services are provided as arranged, while sub-district governments sometimes conduct investigations on the satisfaction level of service users (by community officials or external investigation organisations).

“The income of care workers is connected to their working hours. Sometimes care workers try to cut their labour. They negotiate with older people, ‘the care service payment for me is ¥18 RMB (£1.98) per hour; if I do not come to work, I can give you ¥5 RMB (£0.55) for each hour and get my payment as usual; you just need to tell those investigators that I have finished the job.’ Some older people accept this offer to get money instead of services. This makes a waste of public resources.”

Ju, executive of a care agency

The fieldwork data show that the monitoring and inspection process is not generalised at the city level in Shanghai, where regulatory actions are usually conducted for each sub-district or even each incident. Monitoring processes in different quasi-market models are subjective decisions made by sub-district governments. Even in Pudong District, the front line of the development of social welfare and policy in Shanghai, there is no detailed guidelines about monitoring and inspection of the care market.

“The state may cooperate with the care industry association to set up basic standards for care practice. For example, what kind of home care services older people can choose and what outcomes they should expect. There are many agencies providing services. Currently, we (local governments) evaluate service quality based on our subjective judgements, which one is good, which is bad, then we choose the better one. In this context, there is too much personal subjective influence involved in this process, which has negative impacts on the development of the care industry.”

Zhan, government official at the sub-district level

The assessment of regulatory activities in care provision for older people echoes the argument made by Tai (2013) on public purchasing of social services in China, which faces inadequate or dislocated regulations and the lack of an evaluation system. Some interviewees suggested the necessities of regulations made by the state and within the care industry. Specifically, unfair competition between providers, the vulnerability of individual consumers (older people and their families), and inequality between older people were key issues raised by interviewees for regulatory measures. Participants in my fieldwork generally showed supportive attitudes towards developing more detailed and standardised regulations in the field of home care. Most recruited local government officials at the sub-district level were happy to transfer the paternal control to the normative regulation, while suggesting that the regulatory procedure would take a longer period than the development of the care market.

To promote the inspection of care delivery to be more feasible, both government officials and care providers emphasised the urgency to carry forward the standardisation of care services. The standardisation includes multiple aspects, such as facilities and equipment of care agencies, charges for service fees and introduction fees, qualifications of care workers, care labour training, and the inspection and evaluation of care provision. On one hand, local government officials suggested that they would like to get a standardised “handbook” to regulate behaviours of care providers and to guide the monitoring and evaluating processes for government officials. On the other hand, most owners and managers of care agencies also prefer to get a framework of regulations to supervise and inspect providers in the market. They suggested that getting objective evaluation standards is beneficial for the long-term development of the market.

“From the care providers’ perspective, we wish to get a reasonable price for standardised services and more technological products, in order to support the care services and to reduce the cost of human resources.”

Wang, care manager

“It is urgent to set up systematic standards for care services, which can promote the professionalism and standardisation of the care industry.”

Yang, owner of a care agency

In addition, the current policy preference to “help the most vulnerable group” (see Chapter 5) adopted by the state also faces criticisms on its implementation and resources allocation

process. Specifically, some local government officials suggested that the evaluation system is not rigorous enough to figure out who is the most vulnerable group, because there are few checks on the economic background of the household (e.g. some people transfer money and property to their families before applying) and the authenticity of paperwork submitted by applicants. In this context, these local government officials argued that the state needs to set up regulations for stricter income check and property check for the admittance of entitled benefit recipients.

“When the group of state-paid service users is expanding, we must coordinate the regulatory system for the admittance control, such as income check, property check. If older people have enough income or property, they should pay for themselves rather than cramming into the subsidy group. At care homes in the city centre, so many wealthy people have taken the limited public resources. It is unequal for others. So, in terms of subsidies for home care services, we must carefully check income and property of older people before they get access to the subsidy system.”

Hao, government official at the sub-district level

### *Conclusion*

This chapter has discussed outcomes of the marketisation of care in urban China on topics of efficiency, competition and for-profit motives on the supply side, care quality and the empowerment for older people, and the regulatory system. Based on characteristics and outcomes of the quasi-market, it has been identified that the development of marketisation of care is at an initial stage in urban China.

The supply of care services in the market has been significantly increasing, but care demands of older people are not fully presented in the market and still far from satisfied. The supply side of care provision has gradually become competitive in the market, but the competition is not fully open or equal to all participants. The admittance into the care market and processes of commissioning and delivery of state-paid care schemes rely heavily on the preferences of local governments, while large for-profit care providers are aggressive to expand their service coverage and exclude other agencies. The shortage of the care labour force and difficulties in recruiting and retaining have been examined as obstacles to the expansion of care service supply and the sustainable development of the care market. In the

context of the implicit boundary between for-profit and not-for-profit organisations, this chapter has investigated disputed understandings of for-profit motivations of care providers.

The increase of service supply and competition in the market has not improved care quality, gaining less attention from the state and service users when compared with the availability of services. Cost and efficiency are suggested as the most important concerns for both direct purchasers (older people and their families) and public purchasers (local governments). During the developing path of the care market, choices for older people are slowly broadening, but still at a low level and unequal within the group based on their economic background.

Finally, regarding the analysis of the legal framework, the accountability of the state in the care market, and the regulatory performance, the development of the regulatory system is much slower than changes in dimensions of care provision and finance. Chapter 8 will bring together my findings and existing knowledge to discuss the marketisation of care in urban China in greater depth.



## Chapter 8 Discussion

---

### *Introduction*

In the context that the traditional family-centred care system is no longer sustainable, the emergence of the marketisation of care in urban China conforms to the demographic and socio-economic changes. The findings of this thesis contribute to filling the gap in the theoretical and empirical knowledge of the marketisation of care in urban China. Bringing together my findings and the existing knowledge, this chapter broadly discusses three themes. It begins with an exploration of the policy process of the marketisation of care and the policy implementation gap in China. The second section draws the “care diamonds” in regard to the dimensions of care provision and finance in urban China, with interpretations of how care diamonds are shifting and the meanings of trade-offs between each sector. As for the regulatory dimension, the dominant role of the state in the quasi-market is examined as well. The third section proposes the marketisation of care as a realistic approach in the ageing context that could benefit from the reconceptualisation of ageing and care for older people and high-level intergenerational support in China. It then investigates different attitudes of stakeholders towards the marketisation before a brief conclusion.

### *8.1 Policy Implementation Gap of the Marketisation of Care in Urban China*

The large gap between policies made by the Chinese central government and implementation outcomes at the operational level has been widely critiqued, such as in the fields of environmental policies (Ran, 2013; Wu, et al., 2017; Lo, 2014) and health system (Yang, et al., 2015). Yet, the policy process in the field of care for older people has not gained much attention from researchers and policymakers and implementers. Findings of this thesis suggest the importance to understand the process of policy-making and implementation in the care field in China, especially in the rapid marketisation context. In this section, policy-making and implementation are examined with reference made to key theoretical models of the policy process (see Chapter 3). Emerging problems in the process of the marketisation of care are highlighted.

Section 8.1.1 examines the pathways through which the marketisation was put on the political

agenda and the characteristics of the policy process in China and clarifies the hierarchy of power in the policy process. The policy implementation gap in China with regard to introducing the care market shows the hierarchical levels and power balance and problems embedded at each level. More specifically, I discuss the policy implementation gap in terms of the marketisation of care in two dimensions: inherent bureaucratic obstacles at practice level (see Section 8.1.2) and lack of knowledge of practice at the policy-making level (see Section 8.1.3).

#### 8.1.1 Policy process and power hierarchy

Referring to the pathways of marketisation policies applied in China (see Chapter 3), the policy process in the field of care for older people in Shanghai is similar to the procedure in other fields (e.g. the national medical insurance reforms). It experiences agenda setting, policy making, policy implementation, and maintenance or termination in a compressed time (since the 2000s). According to the accountability of different levels of governments (see Chapter 7), the policy-making in the field of care for older people in Shanghai is controlled by the central government and the municipal government; the sub-district governments implement policies and follow up and submit feedback to superior governments; policy-making governments then make decisions on whether to expand the policy coverage, maintain or terminate the trial schemes. In general, the policy process in the field of care for older people in China involves a large amount of political and administrative orders other than research or practice evidence.

During my fieldwork, one government official and one care provider cited the same statement that care for older people in China is at the stage of “a person crossing a river by feeling his way over the stones”, which implies to make and implement policies and schemes boldly and consciously (see Chapter 3). Considering the historical and political background, it is an understandable choice for China in the 1980s to “cross a river by feeling stones”, because that is an unprecedented moment for China to start socio-economic reforms. Yet, significant demographic and socio-economic changes have taken place in recent decades. China’s marketisation and industrialisation processes surprise the world (Fan, Wang and Zhu, 2011; He, et al., 2016), but the policy-making, implementation, and monitoring process keeps to the

old path of the 1980s.

In the context of developing the care market in urban China, problems are inherent in each stage of the policy process: the urgency to set up the legal framework and the explicit accountability of each level, little evidence involved at the policy-making stage, lacking monitoring and inspection during policy implementation, little attention to the evaluation of outcomes and crude decisions on policy maintenance or termination. Chapter 7 has strongly suggested that the policy-making process needs to be improved to keep pace with the marketisation of care. Various evidence (e.g. practical experience, implementation feedback, and evaluation of trial schemes) are available in practice but have not been taken into sincere consideration by policymakers.

The policy process reflects power relations. Referring to typical types of the power hierarchy, Scott (2010) suggests that it can either be centralised or diffuse. The policy process in China generally falls into the “centralised” power hierarchy, which implies the policy-making authority is much stronger than the civil society, where government decisions are more likely to be effectively carried out in a smoother process. The policy-making and implementation in China are crudely efficient with fewer influences from different stakeholder groups. Yet, the quality, effectiveness and persistence of policies are as important as the time-cost of the process, which needs more attention from policymakers in China’s context.

The centralised top-down system in China and the complex hierarchy within the government have impacts on its policy-making and implementation process. As Li (2010) argued, the central-local relations in China were on the “decentralisation” trend in the 1980s, which then has turned to a “re-centralising” phase since the 1990s. Yet, she also suggests the differences of the centralised powers between the Maoist period (the 1950s to the 1970s) and in the current stage: changing from the “micro, production and allocative” powers to “macro, regulatory and redistributive” powers. Evidence from my fieldwork data show that the implementation gap exists between central and regional policy-making governments, local administrative authorities, and different departments in the government.

During the decision making and revision process, policymakers barely collect information or

feedback at operational or practice level (e.g. local government officials, care providers, service users) in Shanghai. Located at the operational level in the top-down system, local government officials that participated in my study argued that their feedback and viewpoints can barely influence the policy-making process. As discussed in Chapter 6, some community officials and care providers (especially those in the older age group who were in their 50s) held the view that their voice was never important to policymakers. In terms of the rationale behind it, a few interviewees contrasted policymakers as elites to the mass, emphasising the large distance between the decision-making level and the operational level (e.g. implementers, providers, and recipients). For example, Hao, a government official at sub-district level argued that policies are made by specialists, government administrators at top level and some academic experts, without any involvement of local government officials, which as he quoted, follows the “Theory of Differences in Intelligence Quotient” (*zhishang chabie lun*).

Nevertheless, some of the interviewees recognised that the policy-making process had started to involve feedback from local governments and independent care providers in recent years. Some care providers and local government officials had been invited to attend meetings to discuss care policies and practice issues with government officials at higher levels. Ju, an executive of a home care agency, exemplified that the “*National Development and Reform Commission*” and the “*Bureau of Civil Affairs*” had invited some care providers to participate in government meetings, where care providers were able to get their voice heard at the decision-making level. Yet, it is still unlikely for local government officials or care providers to get realistic impacts on care policy. It is at an early stage for the Chinese government to collect information or feedback from implementers and practitioners, who have not achieved influential status or taken part in the decision-making process.

Regarding the policy implementation, local governments take an influential role at the operational level. Interviewed local government officials working at the sub-district and community levels are a representative group in the care field in Shanghai. These interviewees were actively involved in the marketisation process in terms of the policy implementation, monitoring and inspecting, as well as being equipped with information on care demands at

the front line and feedback from older people. As key players in the care market, local government officials work as a mediator between policymakers and practitioners and service users, which in the meantime leads to heavy workload coming from both top and lower layers.

Even though the market has no power to interfere in the policy-making process in China yet, care providers focus their influence at the policy implementation level when they negotiate with local governments. As discussed in Chapter 7, the interactions between providers and local governments in the under-developed regulatory context lead to risks of unequal competition and the oversight of care quality and the delivery process. Referring to the participation of the private sector, Matosevic et al. (2011) argued that more self-interested concerns might give more priorities to financial profits, professional development, and agency independence. If there exists an excessive involvement of care providers in the decision making, providers with advantaged status might skew the market in their favour. Policymakers need to take into consideration the risks of the increasing involvement of providers at policy-making level and harmful behaviours at policy implementation level and in care practice. For instance, bribery and preferential treatment are associated with an unopen commissioning process and insufficiently monitored care delivery process in China.

Based on the discussions on stages of the policy process and the power hierarchy, the following sections focus on the characteristics and barriers at the practice level and decision-making level in the field of care for older people, respectively.

#### 8.1.2 Inbuilt bureaucratic obstacles at practice level

Similar to the multi-layer problems identified by Hill and Hupe (2003) in the policy implementation process, I examine the policy implementation gap in the care field in urban China through the dimensions of legitimacy or disobedience of implementers and the poor knowledge about the practice of policymakers. More specifically, this section discusses the barriers to policy implementation at operational level, while the next one (Section 8.1.3) examines relevant failures at the policy making level. Barriers at practice level are discussed in the following aspects: administrative inefficiency; the inconsistency and insufficient communication and cooperation between different government departments; poorly monitored autonomy and personal influences of executive leaders in policy implementation;

and the procrastination of local government executives in practising discretionary power. It then explores the rationale behind local government decisions on the exercise of their discretionary power.

First, administrative inefficiency at practice level was proposed as noticeable barriers to the implementation of “good” policy by many care providers that participated in my study. According to the fieldwork data, too many layers within the government and the complex divisions and overlapped accountability of departments led to the inefficiency of policy implementation. The reduction of layers between policy-making level to operational level was thus suggested to improve the efficiency and effectiveness of the policy transmission. For example, as discussed in Chapter 7, a few owners and managers of care agencies argued that many primary objectives of central or municipal governments cannot be put on the ground, because of layers of bureaucracy.

Considering the time taken for the policy implementation process, it is inefficient to some degree to get care policies down to the ground. Many care providers complained that it took too long to get “macro” policy to be “feasible” in implementation. For example, the “*State Administration for Industry and Commerce Department*” in the central government issued a policy to start the application of “enterprise” licences for care providers in 2015. When I conducted the fieldwork in April 2016, this policy had reached Shanghai at the city level, which was processed by the “*Market and Quality Supervision Commission of Shanghai Municipality*”. However, the municipal government stated that the applications can only be submitted to district governments, so care providers had to wait longer to get registered with this licence at local level. In this context, home care providers in Shanghai still run as “social service agencies” rather than “enterprises” (see Chapter 7).

Second, the inconsistency and low cooperation level between different government departments is another bureaucratic obstacle in the policy implementation process. In the context that the accountability of different departments in governments is not explicit in some areas (see Chapter 7), care schemes made by different departments in Shanghai are not always in coherence with each other. For example, Hao, a government official at the sub-district level, indicated that it is not an unusual problem that care policies made by different

offices (e.g. “*Office for Care for Older People*” and “*Office for Social Welfare*”) within *Shanghai Bureau of Civil Affairs* are isolated from each other. According to the interview data, the boundaries between these departments overlap, involving convergences of working responsibilities and leading to contradictions of policies and projects proposed by different divisions.

With limited internal communication between government departments, public resources sometimes are repeatedly allocated to the same group by different departments, while leaving other groups with little or no support from the state. For example, when different departments in Shanghai repeatedly allocate welfare to the same “prioritised” group (e.g. disabled older people, household income lower than the poverty line), the majority of older people keep being excluded from the benefit recipient’s group. According to the fieldwork data, some older residents who were categorised as prioritised welfare recipients can get access to various financial support and services allocated from multiple sources (different governments or departments), which led to the situation that some benefit recipients were no longer economically disadvantaged. It was exemplified that frequent subsidies and material goods had been provided to disabled older people in one jurisdiction, which came from different offices of the Bureau of Civil Affairs (e.g. Office for Ageing Issues, Office for Disabled Group, Office on Poverty Issues) and several levels of government (e.g. city, district, sub-district) and different departments in these local authorities. Local government officials in this jurisdiction argued that these disabled older residents with multiple benefits became generally richer than a large amount of the unprioritised group.

Third, in the context that local governments have the autonomy and discretionary power in policy implementation, executive leaders have personal influences on the decision-making in each jurisdiction. The “openness” of personality and management styles of executive leaders were reported as key influential factors for care policy implementation and care practice in each jurisdiction. Local variation and initiative are significant in the political system in China (Lieberthal, 1997; Ran, 2013). As cases exemplified in Chapter 6, local government officials and care providers argued that whether their working proposals could be approved or not depends heavily on the personalities of senior administration officials in local government (i.e.

head and deputies of sub-district authorities).

Even though they have been granted the power of discretion, local government executives are still unlikely to move forward when detailed instructions are not issued by top level. Unlike the difficulties of local authorities proposed by Hardy and Wistow (1998) in the UK context in the 1990s, “resource constraints” or “budget pressures” were not reported as restrictions for the expansion of care schemes in Shanghai. Instead, during my interviews, government officials at the sub-district level had a consensus that most local governments in Shanghai had enough budget to increase financial support for older people (for the coverage of benefit recipients and support level of subsidies). The surplus of annual budgets in the field of welfare was a common phenomenon shared by local government officials working across different jurisdictions. The fieldwork data suggest that executives of local governments have low willingness to swiftly allocate money to the welfare sector.

Considering the rationale behind the situation that local governments do not swiftly exercise discretionary power, the political priorities on “stability” and “protecting the most vulnerable group” and the subjective procrastination were proposed as the main obstacles at policy implementation level. Referring to political priorities, a few interviewees suggested that the “stable” or “harmonious” society with fewer disparities, arguments, or complaints is the top concern for most local governments. As analysed in Chapter 6, many local governments embrace the political philosophy of being a “happy medium” and prefer to keep a “stable” society. For example, complaints and unstable situations in one jurisdiction was suggested to be worse than delaying the implementation of policies. In this context, local governments prefer to keep things quiet in each jurisdiction to maintain a so-called “equal society” with their neighbours.

The paternal political background and the cultural and ideological emphasis on equality are identified as two main explanations to this political idea. First, paternal management by the central government and strict bureaucratic hierarchy are embedded in the Chinese political context. Based on their work experience in the paternal system, some local government officials have gotten used to the top-down system, with less willingness to take active actions without superior orders. On one hand, “passive” coping strategies are commonly applied by



local governments. For instance, several government officials participating in my interviews argued that the deliberate delay in the policy implementation was a common choice for local authorities when new care policies or schemes are issued by top level. On the other hand, some local government officials argued that the heavy workload at the implementation level stops them swiftly acting as new policies are suggested or constantly paying attention to the care sector when issues in other fields are also waiting for them. The fieldwork data show that local government officials working in the care field have work duties in many other fields. The operational level cannot be solely engaged with any specific topic.

Second, the traditional philosophical idea of “inequality, not scarcity, which persecutes people (*bu huan gua, er huan bu jun*)”, which was cited by an interviewee (see Chapter 6), has impacts on Chinese politics and the marketisation path. A government official suggested that plenty of Chinese people harbour antipathy towards inequality, expressing happiness in more equal but poorer conditions rather than richer but less equal conditions. Advocates of this philosophy argued that the policy implementation path is delayed in consideration of the dissatisfaction of the public on inequality, which on the contrary was critiqued as irresponsible and inefficient behaviours of local government by some other interviewees. Inevitably, the marketisation increases inequalities in the process, where older people’s purchasing power depends heavily on their economic background (see Chapter 5). It is highly unlikely to promote the marketisation of care and reduce inequality among older people at the same time. The consideration of balancing these two (and other) interests leads to a dilemma for policymakers and implementers, which sometimes represents as delays in policy implementation.

#### 8.1.3 Lack of knowledge of practice at decision-making level

In addition to the barriers at operational level, the policy implementation gap also involves complexities and problems at policy-making level. For instance, the failure of the central government in encouraging the implementation of policies has been recognised as an important reason for the policy implementation gap of environmental policies in China (Ran, 2013). Ran (2013) critically argues that the Chinese central government’s incentives for making some policies are not to get them fully implemented; instead, policies are expected

to be either not or poorly implemented. Empirical data and document analysis suggest that most Chinese policies in the care field are not practice-focused or well-made for implementation.

It has long been recognised that ideal policy-making only exists in theories rather than in the real world. Lindblom (1959) clarified that it is impossible to practise the “rational-comprehensive method” for complex issues, considering difficulties such as disagreements on critical values or objectives, conflicts between objectives, or different matching between objectives and values. This section focuses on influential factors at policy making level that are closely connected to the policy implementation gap in the care field in China, rather than discussing the difficulties during the decision-making process. To be specific, I identify limitations at decision-making level in terms of marketisation policies, including the infeasibility of policies and rationale behind it, underestimation of operational level and practice knowledge, little involvement of policy implementers in policy-making, the rough efficiency of policy-making, and the questionable sustainability and effectiveness of policies.

Some local government officials who participated in my fieldwork argued that the infeasibility of policies, rather than bureaucratic layers or the poor performance of local authorities, should be responsible for the situation that policies cannot be well-implemented in practice. They suggested that policymakers (at central and city governments) and decision-makers of the practical marketisation schemes (sub-district governments) know little and care less about care practice, which results in the situation that some policies and schemes are either poorly conceptualised or unfeasible for practice. Sometimes decision-makers in China do not have a good understanding of policy objectives themselves, which echoes one reason proposed by Hupe and Hill (2016) for the policy implementation gap: policymakers may fail in politically mobilising the understanding of policy objectives.

Specifically, some government reports from the central government are impressive but impractical. When these policies come to the practice level of *jiedao* (sub-district) and *shequ* (community) which likely remain in their original format, problems are detailed, specific, and complicated. If a new policy is issued without guidelines, especially when it cannot reflect the complexities of practice or contradict practical situations, local governments choose to wait

for further instructions from superior governments rather than practice discretionary power (see Section 8.1.2). This process inevitably defers the policy implementation and leads to the increasing dissatisfaction from the public towards local governments, because the public has little idea about the levels of policy-making and implementation, the accountability of each level and the capacity of local governments.

Based on the analysis of policy documents in the field of care for older people, Chinese policies and plans are generally drawn in a macro and abstract format, which involves little consideration of the practicalities while leads to ambiguity in the discretion. For example, the Chinese central government issued a policy in 2008 to promote home care, suggesting that the role of the government is to establish strategic plans, provide land, facilities, and financial investment, set up standards, and monitor and evaluate, instead of directly providing services. On one hand, this document is a milestone policy in the care field, which was treated as a “most detailed” statement on the changing role of the state by local government officials in my interviews. On the other hand, interviewees strongly criticised that this document only shows a list of strategies without any practical guidelines or specific boundaries for the discretion of local governments as well as no follow-up explanations or interpretations.

Local governments are entitled to implement policies with their own interpretations, while taking the responsibility for (especially negative) consequences and blame even if the problems are embedded in the policy itself. It is a common situation in China across different policy fields that policy implementers get blamed for the implementation gap or failure by both top level and the public. Some interviewed local government officials argued that they (as policy implementers) have to face the criticism of failures in policy implementation regardless of the reasons. For example, Wei, a government official at the sub-district level, argued that “local government staff are always the ‘bad guy’ for not implementing ‘good’ policy issued by the superior governments.”

The underestimated discretionary influence of the operational level is argued as another reason for the implementation gap by Hupe and Hill (2016), which is evidently represented in the marketisation process in China. Referring to the policy process and power hierarchy in China, it has been argued that policymakers barely collect information or feedback from the

operational level or care practice in the context of the centralised top-down system. Considering participants in the policy formulation and their roles in the context of the European Union, Cram (1997) suggested that “implementation failure” was highly likely to be connected to the situation of policies being formulated without the active involvement of implementers. The involvement of practical knowledge and participation of implementers are necessary for the policy-making process in China, especially in the care field.

Besides, even though the reaction time of policy implementation is relatively rapid in China (Li, 2010; Kostka and Hobbs, 2012), it does not make the implementation and the top-down delivery of policies in China comparatively “efficient”. As discussed in Section 8.1.1, the policy-making process in China involves little evidence-based research, feedback from the front line, or internal and cross-sector communication. It is common that policies across different fields are tested immediately in practice, which involves little evidence from research or implementation feedback. Policymakers continue to set up new policies targeting to address (or just tick off) problems on their agenda, without evaluating potential outcomes of each policy. The sustainability and effectiveness of policies are questionable, which also explains the contradictions between policies made at different periods or made by different departments.

To sum up, after clarifying the hierarchy of power in the policy process in terms of the marketisation of care, this section discusses the reasons for the policy implementation gap at two dimensions of the practice level and policy-making level. On one hand, bureaucratic obstacles impede the policy implementation process, such as administrative inefficiency, time-consuming implementation process, inconsistency between governments and departments, repetitive allocation of funding to a small group. Meanwhile, the discretion of local governments in promoting the marketisation of care is not fully practised, influenced by political priorities on keeping a “stable society” and subjective procrastination. On the other hand, the decision making level in China fails in understanding practice and implementation outcomes, which results in poorly conceptualised or unfeasible policies. Perceptions of top-level policymakers on the implementation and the low effectiveness of policies sometimes disrupt local governments to achieve determined objectives.

## *8.2 Shifting Dynamics of the Care Diamonds in Urban China*

The process of the marketisation of home care reflects the care regime shifts in urban China in recent decades. The application of market mechanisms has impacts on participants in the care market and on all sectors of the care regime (i.e. the state, the market, the family, and the community), which leads to changes in the shapes and implications of the care diamonds. As discussed in Chapter 2, the care diamond diagrams drawn in this thesis were developed from others that take China as one single case without identifying characteristics in different dimensions of the mixed economy of care. Unlike those care diamonds in regard to social care (including childcare and elder care) based on cross-sectional studies, the diagrams drawn in this section exclusively focus on the qualitative understanding of care for older people in the specific area (urban China). The in-depth illustration contributes to the knowledge of how different sectors have been shifting in recent decades in the dimensions of care provision and finance.

Considering the pathways of the Chinese quasi-market, the marketisation of care does not feature in the context of a welfare system as in Europe. The shape of care diamonds in urban China is distinct in many aspects. First, a strong state is an overriding factor in the policy process (see Section 8.1) and the entire welfare field in China. Chapter 6 identifies three models of the quasi-market in the context of the top-down political system in Shanghai, showing the hierarchical relationships between governments and care providers. As analysed in Chapter 7, powerful politicians sometimes make a difference without making or taking a standard procedure. The state in China has strong power in every aspect of the society, on a scale that has never been shown in Western Europe.

Second, even if the role of the family in care provision has gradually degraded due to significant demographic changes in China, it is still extraordinarily active in different dimensions of care for older people. My fieldwork data suggest that cultural norms on filial piety remain embedded in the Chinese care system (see Chapter 5). As a traditionally family-centred country, those marketisation strategies and processes in familial welfare states in Europe (e.g. Italy) and East Asia (e.g. Japan, South Korea) have been extensively applied in Shanghai as well, which will be discussed in Chapter 9.

Third, the rapid and compressed path of economic development and marketisation in urban China is unprecedented in the global context, which is shaping its care system. After the 1980s, the market dramatically increased in the field of care for older people. Socio-economic reforms in urban areas are evidently influenced by the marketisation and globalisation trends. As discussed in Chapter 3, even though the increasing care demands are widespread across China, urban residents benefit from the rapid economic development, the inflow of rural migrant labour, increasing welfare benefits, and the active participation of independent care providers. The emergence of the marketisation of care is in accord with these demographic and socio-economic changes in urban China.

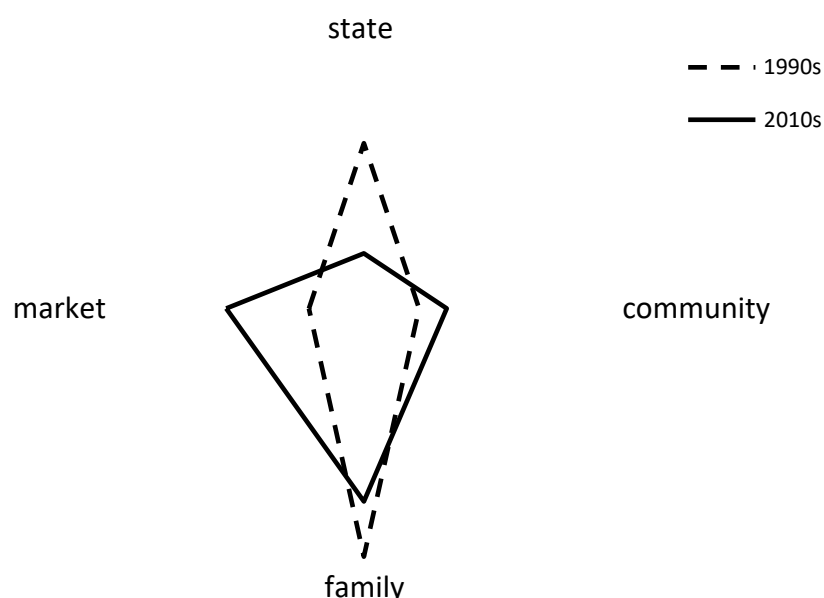
Besides, the community (including volunteers and functional organisations constructed by the state) provides reliable support to older people in urban China (see Chapter 5). Volunteer groups who provide emotional support and frequent visits help fill an important part of the care system, especially for the gap that has not been covered by other sectors. Community officials take on multiple duties in care practice: work at the front line on behalf of government officials to help arrange financial support, collect data, deal with care complaints; report care incidents to local governments and sometimes act as agents on behalf of older people; and coordinate and cooperate with volunteer groups in each jurisdiction.

Based on the findings, I have developed the care diamond diagrams hypothesised in Chapter 2. Care diamonds proposed in this thesis aim to illustrate comparative conceptual changes of each sector in different periods and cooperation and trade-offs between them during the process. These diagrams describe a process rather than attempt to measure the extent of change (i.e. sizes in the diagrams do not show quantitative meaning). This section does not draw care diamonds in the regulatory dimension because it deviates to the state sector (without showing a “diamond”); instead, the strong role of the state is identified in various aspects in the last part of this section.

#### 8.2.1 Care diamonds in the care provision dimension

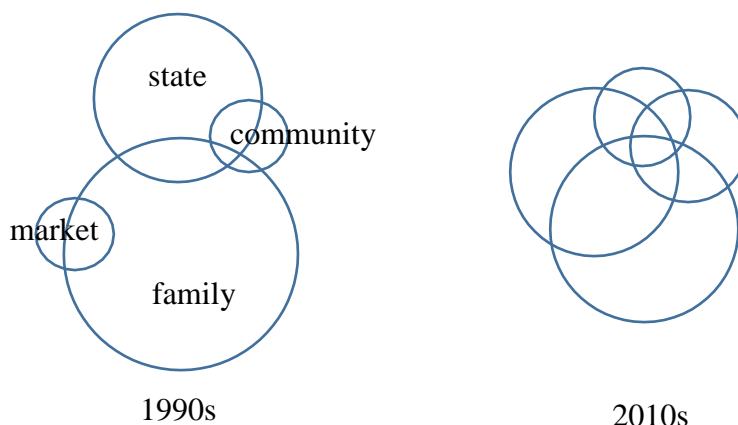
Figure 8.1 and 8.2 demonstrate the care diamonds in the dimension of care provision in the 1990s and 2010s. Compared to the period when social care started to embrace the market-oriented reforms (1990s), findings of this thesis support my preliminary hypothesis that

connections between the state, market, family, and community have increased in recent decades. Figure 8.1 shows the changing shapes of the care diamond at different periods in the same scale, which makes the longitudinal comparison visual.



*Figure 8.1 Care diamonds in the care provision dimension in the 1990s and 2010s - for longitudinal comparison*

As drawn in Figure 8.1, the shape of the care diamond in the provision dimension in the 2010s is supposed to be less sharp than in the 1990s, showing retreats of the state and the family and increases of the market and the community. As typical conceptual characteristics of the marketisation of care, the market and the community have become much more active since 2010, while family care has gradually decreased and the state is pulling out from the direct care provision (e.g. the state provided “cradle to grave” support to employees in state-owned-enterprises up to the 1990s). Considering each sector in the care diamond, the family is still an important care provision source for older people in the 2010s, but the dependency on the family has decreased in recent decades in urban China. The growth of the market and the decrease of the state in the care provision dimension are even more rapid than hypothesised in Chapter 2. The increasing importance of the community is unexpectedly significant in providing practical and emotional support to older people.



*Figure 8.2 Care diamonds in the care provision dimension in the 1990s and 2010s - for dynamic changes in shapes and relationships between each sector*

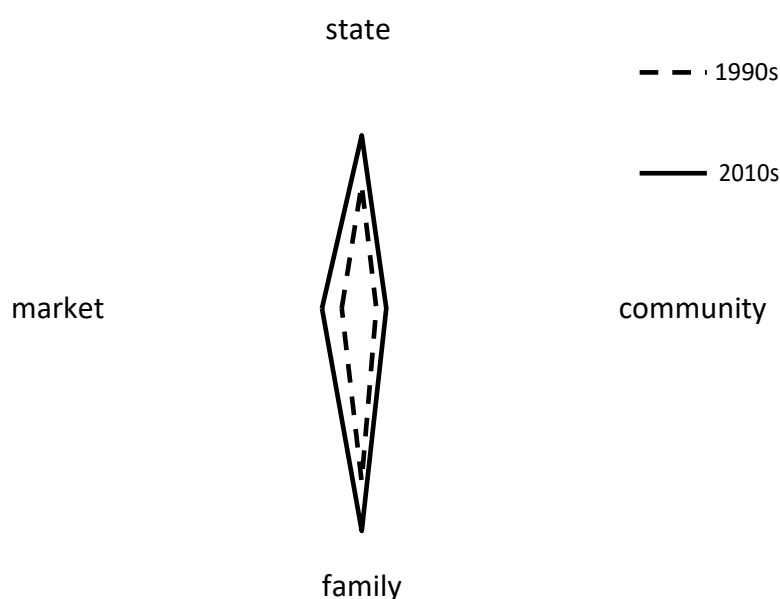
The shapes in Figure 8.2 show the changes of each sector and the shifting connections between them. Trade-offs and cooperation between these four sectors (shown as overlapped areas in the diagrams) have considerably increased in the dimension of care provision in urban China. The changing role of the family and its connections with the other three sectors was discussed in Chapter 5, which elaborates the rationale behind the phenomenon of home care as the basis of the Chinese care system. The community in urban China cooperates with different sectors, working as a further arm of the government at the front line, the agent to report feedback on behalf of older people, and the coordinator between volunteers and care providers. The quasi-market discussed in Chapter 6 illustrates the changing relationships between each sector (especially focusing on the state-market relations).

As described in Figure 8.1 and 8.2, the shifting shapes of the care diamonds in the provision dimension shows the emerging trend of the marketisation of care in urban China, which involves increasing cooperation and trade-offs between each sector: families seek care services from the market; the state tries to keep away from direct care provision while actively encourages and motivates the participation of the other three sectors; the market has developed rapidly in a short period (since 2000) with ambitious goals to provide care to older people and gain profits; the community retains its reliable role for older people while has more cooperation with volunteers and providers in the market.

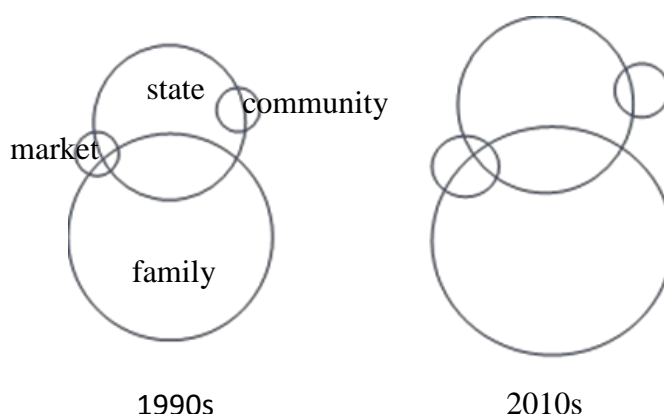


### 8.2.2 Care diamonds in the finance dimension

The shapes of care diamonds and changes of each sector in the finance dimension are different from the provision dimension. Specifically, the role of the state and the family have grown to be more substantial in the dimension of finance since 2010, while the increase of the market and the community is not as significant as that in the care provision dimension. Based on the fieldwork data and analysis of policy documents, Figure 8.3 and 8.4 demonstrate the models of care diamonds in the finance dimension in the 1990s and 2010s. Shapes of the care diamonds in the finance dimension look similar in these two periods. As shown in Figure 8.3, the care diamonds in the finance dimension constantly have sharp points at the state and the family sectors in both periods. The size of each sector has gradually expanded but not changed as significantly as in the care provision dimension. The connections between each sector have no substantial changes either (see Figure 8.4).



*Figure 8.3 Care diamonds in the finance dimension in the 1990s and 2010s - for longitudinal comparison*



*Figure 8.4 Care diamonds in the finance dimension in the 1990s and 2010s - for dynamic changes in shapes and relationships between each sector*

However, not only does the expansion or decrease of size matter in interpreting the shifting care diamonds. According to the documentary analysis and my empirical research, there were substantial changes in the compositions of shapes in the finance dimension from the 1990s to 2010s, especially in the state sector. As defined in Chapter 2, the financing dimension embraces financial support to older people from different sources, including maintenance and living expenses paid by families, state and private pensions, social expenditure, insurance and other expenditures. This section explains the implications of these diagrams by exploring the socio-economic and policy context, changing methods of financial support, priorities of the state, and shifts in the other three sectors in the finance dimension.

The finance dimension of care for older people has gone through major changes since 1978 when the “planned economy” started to turn to the “market economy” (see Chapter 3). In the context of the retreat of SOEs on providing welfare to employees, the pension reforms in China were led by the central government and gradually implemented and reviewed. The Ministry of Civil Affairs proposed the idea of the “socialisation of social welfare” in 1984, emphasising the involvement of social organisations and the private sector in the care field, which was reinforced by the central government in 2000 (State Council, 2000). As Feng (2004) argued, the reform of the pension system in China was initially “forced” by state-owned enterprises reforms. In 1994, the Chinese central government issued the “Seven-Year Development Outline on Work Concerning Elderly People in China (1994-2000)”, proposing to raise funds for the care sector through “multiple” methods (no details on what types of

methods were to be involved). In the late 1990s, SOEs reforms led to plenty of laid-off workers and early retirees. The rapid increase of pension recipients and the decrease of contributors (bankrupted enterprises, laid-off workers, early retirees) cast financial burdens on local governments and employers. SOEs and the pension system based on it significantly changed in the 1990s.

In this context, the state started to build a more independent pension system for a larger amount of people instead of allocating financial support concentrated on SOEs and public institutions. According to the “Social Insurance Law of the People’s Republic of China” (2010), basic pension insurance combines the “general social planning account” (employer’s contribution) and the “individual account” (employee’s contribution). The input of the Chinese pension system in the 2010s mainly includes four sources: normal contributions (from employers and employees), profits from the investment of the pension fund, fiscal input from the state, and extra contributions (e.g. prepay, arrears) (Liu, 2014; Zheng, 2016). Zheng (2016) suggests that the individual contribution rate on pensions in China (28%) ranks highly among countries (e.g. OECD average 19.6%). Researchers increasingly pay attention to problems occurring during the Chinese pension system reforms, such as transformation costs of reforms, the deficit of general social planning account, nominal individual account, fragile capital market, and fund management (Feng, 2004; Zheng, 2016). Among these issues, the “empty account” that implies that individual accounts of current contributors are empty because of the overdraft to pay existing retirees (Sun and Maxwell, 2002; Zheng, 2016) is a hot topic in the research literature as well as during my interviews with local government officials.

In addition to the pension system, the state has increased investment in the field of care for older people by providing financial support to the care market. As discussed in Chapter 6, the Chinese government started to change the financial support methods from direct allocation to encourage the participation of social service agencies in the 1990s. The amended “Law of the People’s Republic of China on the Protection of the Rights and Interests of Elderly People” (2015) stipulates that the state ought to encourage and support social organisations or

individuals to establish care facilities, including welfare institutions, care homes, apartments for older people, health recovery centres, and education and exercise centres.

There has been an expansion in the range of recipients of public financial support since 2010; in the meantime, the number of benefit recipients has increased. First, the composition of benefits recipients and care service users is significantly different in the 1990s and 2010s. The old welfare system before the “Reform and Opening-Up” only covered employees of SOEs and a small number of “the most vulnerable group” (e.g. “three-no older people” who have no capacity to work, no income, and no informal support). According to the interview data, the majority of residents in care homes in the 1990s in Shanghai were still “three-no” older people, whose residential fees were fully paid by the state. The prioritised group who can get access to support from the state was then expanded from only “three-no” older people to include other disadvantaged groups, such as the old-old group. In the 2010s, as illustrated in Chapter 7, state-paid home care services in Shanghai are available for older people aged 90 or older, and for those who have lost their only child (born under the “one-child policy”).

Second, the financial support turns from the direct allocation to public care homes to contracting out care agencies or schemes to independent social service agencies and to older people to purchase care services in the market. The state funding is apparently targeted to a bigger group than in the 1990s. In this context, the number of recipients of state-paid services has significantly increased in recent years. Yet, interviewees in my study still criticised the coverage of state subsidies on care services, arguing that the state ought to expand the benefit recipients group who can get access to state-paid home care services regardless of who providers are (e.g. for-profit, not-for-profit, informal market).

Even though independent care providers started to get involved in the care service sector in the 1990s, it was a common view in my fieldwork that the state financial support to public institutions was much higher than to the private sector in that period. For example, “Forest” stepped into the care field as an independent care home in the 1990s. This agency started to provide home care services along with residential care in 2002. The executive of “Forest” argued that the state allocated much more financial support to public care homes than independent ones in the 1990s, which led to the unequal competition between public and

private institutions as well as the disparity of facilities, employees (including care managers and care workers), and reputation between them.

Influenced by the socio-economic changes since the 1980s, the role of the family has also changed in the finance dimension. As discussed in Chapter 3, the living status of urban households in China has changed from the extended family to the smaller nuclear family. Methods of care provision and financial support change when adult children no longer live together with parents. When increasing older people and their families started to seek external care services in the late 1990s, financial support from families to older people turned from paying daily life support (e.g. food, bills) to purchasing care services. As shown in Figure 8.3 and 8.4, this study suggests that the family is becoming more important in the financial dimension of care for older people.

Compared to the changes of the state and the family, the market shows a much smaller rise in the financial dimension (see Figure 8.3), which is also not as significant as the change in the care provision dimension (see Figure 8.1) or as hypothesised in Chapter 2. Several government officials and care providers that participated in my fieldwork suggested that the investment from the private sector into the financial market is gradually increasing in urban China. A few care providers argued that private capital and companies are eager for profits in the financial market in relation to care for older people. Private pension schemes and financial products targeted to older people have seen preliminary development in recent years. Yet, this development path is very slow while the public retains low trust in private schemes in the financial market (especially against the insurance for older people or long-term care). Quite a few Interviewees indicated that scams targeted at older people had destroyed public trust on private financial products. The owner of a care agency exemplified a private long-term care insurance scheme produced by the “Happy Insurance” company, which only got sold to seven older people in Shanghai during 2015.

Besides, unlike in the care provision dimension, the community is not an influential factor in the finance dimension of care for older people. Yet, since functional organisations at the community level represent a further arm of the government in the care field, the increase of state financial support (especially those towards benefit recipients) inevitably stimulates the

community to take action at the practice level in the finance dimension. According to my interview data, community officials occasionally take on the duty to allocate financial support from the state (e.g. subsidies to older residents, vouchers for services) and donations from enterprises or charity organisations to older residents. In general, community officials act as the front line operators, without decision-making or resources allocation power in the finance dimension. Additionally, volunteers are more active in the care provision dimension rather than providing financial support to older people.

The separation of the provision and financing care diamonds provides a useful tool to disentangle complex pluralist performances and inter-sector dynamics in different dimensions. However, the care diamond diagrams do not show the interrelationships between dimensions. Alongside changes of four sectors in each dimension, provision and financing of care for older people are highly interconnected and interacted with each other. For instance, as discussed in Chapter 6, many care providers receive funding from diverse sources, including public subsidies and private investments; the financial support from the state to older people and care providers boosts the care provision market.

To approach a more holistic understanding, it is worth reviewing the separated care diamonds with reference to cases of how different sectors and dimensions are interplayed and integrated in practice (see Chapter 6). Using the mixed economy matrix with social care examples from the 1990 Act in the UK (Wistow, et al., 1990), I developed a matrix to classify the provision and financing dimensions of care diamonds in urban China (see Table 8.1). Matrix cells are populated with examples in the field of care for older people in Shanghai, only except in two slots I use cases in other societies to exemplify unavailable interactions in China. Although not a complete list, this simplified matrix compensates to the separated care diamonds by describing interrelationships between care provision and financing dimensions of care for older people.

Table 8.1 The interaction matrix of provision and financing dimensions of care for older people

		Care provision			
		State	Market	Family	Community
Financing					
State		State-paid services for benefit recipients in public care homes	Home care paid by local authorities and delivered by private providers;  Subsidies to private care providers	not available in China e.g. Hong Kong: Allowance for family caregivers	Community / volunteer services funded by the state
Market		Private care providers' payments for registration and licensing	Private care providers' investments and payments for operations	Welfare from employers for care for parents (e.g. subsidies, gifts)	Corporate donations to older people through the community network
Family and individual consumption	Uncompensated	Payments to public care homes	Payments to private care providers	Intra-family transfer of care and funding	Payments for community services
	Compensated	Residential fees backed up by state subsidies	Care service vouchers	not applied in China e.g. Singapore: Housing grant if living with or near parents	Discounted purchases of community service
Community		Volunteers in public care homes	Volunteers in private care homes	Gifts or services donated to households with older people	Community function branch manages volunteers and donations

### 8.2.3 Dominant state in the home care quasi-market

I have not drawn the care diamond in the regulatory dimension because it is generally inclined to the state with little involvement of other sectors. As discussed in preceding sections, the state is retreating from the care provision dimension with a slight expansion in the financing dimension. This section focuses on a holistic account of the sustained and dominant role of the state during the Chinese marketisation process. Three aspects of the role of the state are identified in the marketisation process of care for older people: 1) state provision (e.g. public care homes, public community care centres), 2) state financial support to the market and older people, and 3) state regulation or control of the market.

The role of the state changes in all three dimensions of the shifting care diamonds. First, the quasi-market in urban China implies the changing path from monopolistic state provision to involve competitive independent providers through the contracting out process. Second, as elaborated in Chapter 6, the state applies various strategies to provide financial support to older people (e.g. subsidies, service vouchers) and care providers (e.g. tax reduction, public purchasing). Third, the state control over the market is overwhelming but the regulatory framework is not well-developed yet (see Chapter 7). According to the interview data, there is no doubt that the Chinese government has influential power in policy and practice in the field of care for older people. For example, the enactment of policies or work plans by governments always has immediate and widespread influence on actions and discussions in practice and research.

Considering the complex role of the state in different dimensions, the fieldwork data suggest that the Chinese government has not matched responsibility with its control of power in the care field in the finance and the regulation dimensions. As discussed in Chapter 6, financial support from the state to older people and the care market is increasing but still at a low level. Home care providers were evidently eager for more policy and financial support from the state. There was a consensus among interviewees (both local government officials and providers) around appealing to expand public financial support for older people and their families and the care market.



Even if the state investment in the care field is much lower than public expectations, it is feasible for local governments to enhance the investment in the care field based on the good economic situation in big cities. As shown in Chapter 3, public expenditure on welfare in China is much lower than other welfare states. Yet, the Chinese state increasingly pays more attention to care for older people and gradually increases social expenditure in the field. The State Information Centre (2015) proposes that the prospective sum of public investment in the field of care for older people during the “Thirteenth Five Year Plan” (2016-2020) would reach ¥290.8 billion (£32.87 billion), with an annual increase of 18.2 percent.

In the context that the state has strong interventions in the process of marketisation of care in urban China, there is a debate on whether “paternal” responsibilities should be taken by the state in practice or not. It is not an easy “good or bad” choice to view strong state power in the care field. Participants in my study held different views on whether restrictions from the state are beneficial or damaging to the development of the care market and the protection of older people. Strong state control restricts freedom and independence of the care market as well as might promote the development of the care market at the same time. On one hand, local government officials and care providers agreed that the basic-level state control is necessary to maintain the order in the care market in the regulatory dimension, such as regulating and monitoring the care market and protecting older people against potential harm due to profit-driven motivations of care providers (see Chapter 7). The basic state interventions are crucial to protect older people’s rights and to keep a comparatively fair and competitive environment for well-behaved providers.

On the other hand, high-level state control and its supreme influence over the care market was under debate among interviewees. The willingness among participants to keep the strong control over the care market was unexpectedly high; especially surprising was that most care providers in my study were in favour of high-level state control. According to their arguments, service users and care providers expect the role of the state to be omnipotent and “paternal” in the care field. For example, one interviewee proposed that the state ought to change purchasing attitudes by advertising the home care market through state-owned media, based on the assumption that older people prefer to believe government speeches. Government

officials and care providers who endorse the state-controlled model and the limited competition model (see Chapter 6) argued that the competition in the care market cannot be completely free, due to considerations on the protection of service users and smaller local care providers and the comprehensive development of different fields in each jurisdiction (e.g. employment, local enterprises).

On the contrary, a few interviewees (including government officials and care providers) held opposite ideas against the high-level state control. Several managers critiqued that there are too many state interventions and control in the care market (e.g. the “black box” of contracting out state-paid home care projects), which makes the competition unequal to independent providers (see Chapter 7). Some local government officials indicated that “*the public expectation on the government is too high to be realistic*” (Jiao, a government official at the sub-district level). According to the interview data, older people and their families prefer to ask for administrative solutions from local governments when they meet problems in care practice (e.g. mediating conflicts between service users and care workers), which many government officials believed could and should be solved between service users and care providers.

Referring to public comments and expectations on the role of the state, I identify three dimensions: first, in the bureaucracy dimension: asking for the reduction of bureaucratic burdens (e.g. too many government employees, too complicated process, and too many layers of the hierarchy within the government); second, critiquing the traditional socialistic care system: the old monopolistic system that related to inefficiency, low quality and support level, and limited coverage (only for SOEs workers) impedes the market; third, in the context that the state is retreating from the care provision dimension without a sustainable regulatory framework: insisting the state take more duties in both policy and practice in the care field.

### 8.3 *Re-Conceptualising Ageing and Care for Older People in the Marketisation Context*

As discussed in Chapter 3, most research in Chinese academia shows negative viewpoints on the dramatic ageing trend and consequent care gap (Basten, 2013), focusing on hot topics

such as the increasing pressure on families (Su, Hu and Peng, 2017), the funding gap of the pension system (Hu and Yang, 2012; Zheng, 2016) and “left behind older people” in rural areas (Chang, Dong and Macphail, 2011; Yin and Huang, 2011). On the contrary, my study suggests that the marketisation of care shows a realistic approach to be applied in the Chinese ageing context. Several interviewees suggested that the family-centred intergenerational and self-support care system in China will find a way out of the ageing issue, rather than getting destroyed by the increasing care burden. This section illustrates the importance to re-conceptualise sensitive terms like ageing and old-age dependency and how the marketisation approach benefits from the Chinese sociocultural context with high-level self-support and high-level intergenerational support. The discussions on changing attitudes towards the marketisation of care are covered in the last section.

#### 8.3.1 The understandings of “independence” and “old-age dependency”

It is debatable whether the old-age dependency ratio underestimates or exaggerates the severity of the Chinese ageing path (see Chapter 3). In contrast to the view that the real old-age dependency is even more severe than simple old-age dependency ratio (Hu and Yang, 2012), my fieldwork data suggest that the real dependency situation in urban China is more optimistic than that indicated by the simple old-age dependency ratio. The retirement age in China has been settled at 60 for male, 55 for female officials, and 50 for female workers since 1978. It is presumed that most Chinese people stop taking paid work after 65 (the age defined as older people in old-age dependency ratio). However, a large number of older people take unpaid work after their retirement age, such as care jobs (for the spouse, grandchildren, or other family members), farm work, and volunteer work (e.g. community volunteers to the old-old group). For instance, spouse carers were emphasised by many interviewees in my fieldwork as an important group of informal caregivers for older people. Unpaid work taken by older people is a common phenomenon in China, which has not been considered for the definition of nonworking age being 65.

Yet, the simple old-age dependency ratio may not underestimate the seriousness of the insufficiency of pension funds in China. The inadequacy of the pension fund is highly relevant to rapid population ageing. The application of “old-age dependency” concerns more the gap

in “pension” rather than “age”. Dependency on the pension system is evidently significant in China, which to a certain extent explains why negative attitudes are widespread towards the ageing trend and care for older people.

Applying the term “old-age dependency” is contested if it only implies the pension gap. Care for the old-age group involves more than pension fund issues. First, not only is the dimension of financial support important to the care regime but also care provision. Second, in the financing dimension, the pension is not the only income source for older people. Financial support from families and individual savings and aggregated wealth make a difference to older people’s lives, which evidently applies in urban China (see Chapter 5). Even if some older people no longer work after retirement, their own savings and wealth (e.g. housing assets) help them afford a decent life without extra help from the pension system or their children. For example, Qi, a government official at the sub-district level, argued that individual income, savings and house assets are the main sources of financial support for the majority of older people in Shanghai, rather than familial or external support.

I thus emphasise the importance of recognising and respecting the autonomy and independence of older people. As Hockey and James (1993) argued, the application of the term “dependent” leads to the nonrecognition of people’s full personhood and risks of being socially stigmatised. They indicate that dependency is allied to indebtedness and would trap older people in a state of powerlessness. Two dimensions of the dependency of older people are identified in China: on the state or on the family. For the former, the stigmas of welfare and service recipients are gradually decreasing in China, which will be discussed later in Section 8.3.3. Getting access to the entitled welfare is gradually treated as a basic right of older people rather than as a burden to the society.

For the latter, intergenerational support to older family members is significant in China but perceived as “filial piety” and encouraged in sociocultural norms (see Chapter 5). Unlike Western definitions on the independence of individuals, the definition of independence in China’s context usually does not count the family or intergenerational support as dependence, especially for old-age life. For example, many older people are prouder of being looked after by their adult children, which they believe is better than living on their own.

Meanwhile, cohorts' differences in wealth aggregation and purchasing attitudes lead to intergenerational support that is more complicated than the simple model of older people relying on working-age population, which will be discussed in the next section.

Additionally, ageing has been recognised as a business opportunity in the context of marketisation. A few interviewees in my study proposed positive aspects of economic outcomes of the trend of population ageing in China. For instance, Mai, the owner of a large for-profit home care agency, argued that the "sunset industry for older people" could lead to a new direction of economic growth in China. As positive aspects of ageing and care gradually gain attention from market participants, it might be optimistic in terms of the market opportunities rather than older people being treated with more respect. The care market might introduce opportunities for business, but the empowerment level of older people is dependent on their own economic background and family support (see Chapter 7).

The business opportunity has not improved the attitudes or treatment towards older people. When talking about service purchasing, care provision and care relationship, some words commonly chosen by interviewees reflected their negative attitudes towards ageing and care, such as "older people's brains are no longer smart", "older people are stubborn", "stressful younger generations". These unconsciously negative comments from interviewees were surprising, especially when most of them have direct working connections with older people. Once they hold the presupposed idea that older people are "dependent" or care is a "burden", their attitudes towards older people in the working environment cannot be guaranteed to be fair, which would surely diminish the service quality. What is more, the terms "ageing" and "care for older people" are widely applied together with "problem" or "burden" by the Chinese government and the public. Attitudes towards older people and their care needs get influenced by these negative definitions.

The exaggeration of the severity of "old-age dependency" and the excessive application of the dependency ratio might lead to an irrational understanding of ageing issues and prejudiced treatments towards older people. In this context, it is imperative to challenge the social construct of old-age. Sensitive terms like "dependency" and "old" need to be re-defined

and applied with discretions to reduce the risk of unexpected negative impacts on targeted groups.

### 8.3.2 Intergenerational support, family involvement in decision making & cohort differences

Intergenerational support, especially from the middle generation to older people and younger children, is a widespread caring model across the world. Considering intergenerational support in the EU countries, Saraceno (2010) argues that the middle generation bears stress due to the “intergenerational chain” to provide care to older and younger generations. Importantly, the acceptance level of intergenerational support is different in each culture. Caring for oneself is taken as the primary duty for individuals in anglophone or even Western culture, while individuals in “other cultures” hold greater trust in governments and more willingness to get care from families (Seale, 1997; Gott et al., 2008).

Intergenerational support in China is significantly high in the dimensions of care provision and financial support (see Chapter 5). Findings of this thesis suggest that care arrangement is a family issue rather than an individual duty in China. Purchasers and decision makers in terms of care arrangements usually involve spouses and adult children, while care recipients have fewer choices or decision-making power in the process. Even though government subsidies and other financial support are allocated to older people as individual recipients, care policy and practice are targeted to support and persuade families to make better care arrangements. Opinions of family members are commonly taken into account in the decision-making process to produce a collective idea for the family, while the empowerment level of care recipients (older people) varies in each case. In general, older people and their family members are joint decision makers for care arrangements and purchases, which also inevitably involves in internal tensions within the family.

In the context of high-level intergenerational support in China, the “Reform and Opening-Up reforms” lead to the disparity of economic backgrounds of families and care arrangements for older people. In addition to personal experience, the purchasing power and discourse power of older people are linked with historical paths and cohort experience, which indicates dramatic changes in the intergenerational relationships when each cohort ages. Wang and Li (2012) demonstrate that the intergenerational correlation in economic status is 0.83 in China,

which is much higher than industrial countries (e.g. 0.5 in the UK, 0.4 in France, 0.13 in Australia, and 0.11 in Germany), showing strong influences between the income levels of Chinese generations. The situation of intergenerational wealth aggregation and the inheritance of inequality are becoming increasingly significant in China (Bowles and Gintis, 2002; Shi, Sato and Sicular, 2013), which has influential impacts on care practice.

As mentioned in Chapter 5, the wealth aggregated cohort in China is urban residents who were born in the 1950s and the 1960s (currently in their 60s or 50s). These age groups are defined as older people in most research and policy in China, but they are not practically “dependent” on the “working-age population”. In fact, this wealthy cohort provides substantial support to other generations (their parents, children, and grandchildren), as well as composes the main part of community volunteers for “old-old people” aged 80 or over. Care responsibilities of the cohort born in the 1980s and the 1990s (whose parents were mainly born in the 1950s and 1960s) rely heavily on both their own income level and the economic background of their families of origin. Specifically, the care responsibility for those who were born in a richer family mainly focuses on emotional support (older people in turn provide financial support to adult children in most cases). For those from poorer families whose parents have not saved enough money and other wealth assets (e.g. house assets) for their retirement life, the financial duty on adult children is extremely heavy. During my interviews, it was widely perceived that most adult children are not able to independently take filial obligation of caring for their old-age parents.

The 80 or over age group in China (born in or before the 1930s) experienced wars and a period of poverty in their youth. Referring to their attitudes on money and expenditure (see Chapter 5), this cohort is generally thrifty on daily expenditure, especially in terms of purchasing care services. According to my fieldwork data, even if these older people are in need of external help based on their physical and mental health situation, their willingness to purchase services or accept services paid by their children is noticeably low. If family members agree their choices on saving money, the living condition of older people would be tough. Unfortunately, this is not an uncommon situation for the old-old group in China, including residents in developed cities like Shanghai.

In terms of decision makers for purchasing care services, it is likely that family members (usually including the spouse and adult children) rather than older people as service users will be regarded as customers in the care market. It is a dilemma for families and other sectors (e.g. the community, the state) on whether to intervene in these older people's lives on considerations of their life quality or to leave them living as they wish. A few interviewees suggested the unwillingness of the old-old group to consume was one reason for taking family members rather than individual older people as the decision maker for care arrangements. In addition to influences from families, significant government interventions in arranging older people's lives also challenge the private and public division, especially in the socialist context in China. By any means, it is a fact that older people's willingness and choice cannot be protected in the decision process.

As has been noted, the high-level self-support and the family involvement are the foundation of the care system in China. It can partly explain why the simple dependency ratio is extremely high in China, but the care system still works well in practice. However, the care responsibility cast on families might exhaust adult children and lead to the overconsumption of filial obligation, as well as leave older people facing higher risks of being abandoned or abused without a well-developed welfare system. Referring to Arksey and Glendinning (2007)'s argument in the context of the UK, the Chinese government has also given additional responsibilities to informal carers without additional support. Chapter 9 will discuss implications on how to employ and support filial obligation in the marketisation context. Ageing in urban China could be treated in a more optimistic and manageable perspective, in the context of better matching regulations and supporting policies. In this way, different sectors could take actions to construct a more reliable care system for older people and all generations. Care arrangements, familial support and "old age" will get the opportunity to be reconceptualised in the shifting process as well.

### 8.3.3 Understandings and changing attitudes towards the marketisation of care

Increasingly employing the marketisation strategies in the field of care for older people in urban China (see Chapter 6), the central government and local governments generally hold positive expectations on the development of the marketisation of care. This is based on



several hypotheses: the marketisation of care can reduce the care provision stress of the state; the care market will support families to provide care; and families can manage care arrangements in a better way with external help from the market. The marketisation of care expands the supply of care provision by providing more choices for those who would like to purchase care services and can afford them. Yet, in addition to the inequality between the affordability of different groups, the quality of care services is not guaranteed to be better through marketisation (see Chapter 7). This section focuses on attitudes of different groups towards the marketisation of care in China, by discussing the understanding of the marketisation, feasibility of the marketisation in care practice, comments on outcomes of the marketisation of care in urban China, and how attitudes change during the marketisation process.

Considering the feasibility of the marketisation of care in urban China, interviewees in my fieldwork had a consensus that marketisation is a realistic approach for Shanghai and other cities to organise care for older people. The marketisation of home care was argued as an inevitable trend of care for older people in urban China. More specifically, the participation of the market in the care provision dimension not only assists older people, but also helps families (especially previous and current family caregivers) be more active in the labour market and in social activities. Benefits to older people and their families were proposed as an important achievement of the marketisation of home care, which in turn promote policymakers to sustain the development direction. In addition, the “high efficiency of applying the market in resource allocation”, “increasing competition between care providers”, “care industry as a new economic development field”, were proposed as advantages for why the state encourages and supports the market to play an active role in the care field.

Showing supportive attitudes towards the development of the care market in China, the idea of “marketisation of care” is poorly understood by policy implementers, policymakers and researchers. Among the interviewees in my study, many advocates argued that the marketisation of care is an essential path for China. They held superficial arguments that problems in the care field are linked to the bureaucracy of the government, which can be

solved by the marketisation path. However, these interviewees rarely had further clarifications when being asked why and how the marketisation could act better. Considering the rationale behind these statements, the propagandistic and ideological education delivered by the state (in schools, mass media, policy documents, etc.) takes the marketisation as a granted path to solve any problems in the socialist context of China, which may restrict critical thinking on the marketisation topic.

In general, the “marketisation” is being recognised as a “panacea” to any problem emerging in the socialist country. Most academic discussions on the marketisation in China, as Zhang (2006) argued, are in binary forms that pit the market against the state while neglecting the complex role of the state in the marketisation process. It is common that the public and some government officials blame the authorities for emerging problems, claiming that marketisation would fix all these problems. For example, there was an overwhelming view among my interviewees that: *“Only the marketisation process can help solve the problem. We cannot rely too heavily on the state. If you only wait for the state to sort you out (as in the past), you are a dead man already”* (Yue, executive of a care agency).

Nevertheless, specific marketisation strategies in policy and practice were frequently critiqued by most interviewees in my study. When asked for opinions on those specific marketisation processes and private factors, participants proposed both positive and negative outcomes and potential threats of practical steps of the marketisation. As discussed in Chapter 7, almost every government official who participated in my fieldwork had fears about the profit-driven motivations of care providers. Considering the definition of social service agencies and their motivations, one community official and two managers in care agencies impressed their hostility against the “privatisation”, because this term is morally unsuitable to be applied in the field of welfare; instead, charity and public support were suggested as basic characteristics of the care sector. Thus, care providers and local government officials have clear and critical viewpoints on details of the marketisation processes and outcomes, but they take the “marketisation” as an undebatable macro idea for granted, which represents the gap between “saying” and “thinking and doing”.

Different models of the quasi-market of home care (see Chapter 6) reflect clustered viewpoints of government officials in each local government on the marketisation of care, while the application of different quasi-market models has counter-influences on the attitudes of government officials. As illustrated in Chapter 6, two main reasons have been suggested for the application of the “limited competition model”: first, local governments do not trust care providers because of their profit-driven nature; second, there is no monitoring or regulatory framework in terms of the care market available for local governments to follow. After choosing a small number of care providers to take state-paid care contracts, local jurisdictions cast a strong influence on these “trusted” agencies and tried to make sure that they behave as the government requested. Being satisfied with the performance of these chosen care providers, Zhan, a government official at the sub-district level, argued that the sub-district government would like to give them more autonomy for now. He suggested that the free entry, competition and operation of the care market would very likely be achieved when the regulatory framework is better developed (which he believed would take a long time).

It is reasonable and responsible that government officials have doubts on care services provided by social service agencies. As discussed in Chapter 2, there is evidence from different countries about the “failures” and “limits” inherent in the market mechanisms (Forder, Knapp and Wistow, 1996; Lewis and West, 2014). Chapter 7 analysed a few cases where older people and their families were trapped by “information imperfections” in the home care market, such as direct purchasers not getting equal information as providers to make decisions, and the difficulties in monitoring providers’ behaviours and the care quality. With consideration of the vulnerability of older people, especially when they receive services in their own homes, Hardy and Wistow (1998) emphasised that it is imperative to get home care contracts well monitored, reviewed, and settled. The risks during the registration, accreditation and vetting process of care workers discussed in the UK in the 1990s are apparent in the current home care market in urban China, which represents an earlier stage of the marketisation of care. As discussed in Chapter 7, “monitoring” by the state over independent care providers is beneficial to the protection of older people’s rights and welfare.

Similar to viewpoints of local government officials, the public in China usually do not trust the private sector across various fields of welfare, such as hospitals, schools, care homes, and so on. On one hand, it is very common to hear criticisms focusing on the low-efficiency, unfriendly attitudes, service quality, and bureaucratic burdens of public institutions. Paradoxically, most people still believe that public institutions are generally better in many aspects (e.g. quality, safety, motivations) than private ones (luxury high-end private providers which most people cannot afford are not included in the discussion). Preferences when choosing affordable providers are generally concentrated on public institutions as long as service users are able to get access to them.

During the development of the care market in urban China, the path of marketisation and attitudes towards the process have influences and counter-influences on each other. Public attitudes towards private providers are changing, especially for those older people and their families who have gotten involved in the care market. As discussed in the previous section, it is common in China that family members (spouse and/or adult children) make decisions on care arrangements on behalf of older people. During my fieldwork, one community official shared her personal experience on the decision-making process of care arrangements and how her opinions on private care providers had changed.

In this case, her mother suffered hemiplegia and was mostly lying in bed as she described. Her father had provided 24-hour daily care with temporary help from adult children for more than two years. Her parents decided to ask for external help because her father's (as the carer) health situation was getting worse. When the family (parents and adult children) chose care homes for her mother, they preferred public ones. But her mother was not able to move to the chosen public care homes because of waiting lists. After employing a care worker to take care of her mother at home for more than half a year, there was still no position in targeted public care homes. As the community official described, the children took different factors into account, including the financial budget (employing a 24-hour care worker is more expensive than fees for a medium-price care home in Shanghai), health situation of their mother (as the service user) and father (as the caregiver), and the contents of services. They eventually decided to move the mother to a private care home after the half year of home

care. Her mother had lived in a private care home for two years when I conducted the interview. This community official argued that the service quality and work attitudes of care workers in her parents' home and in the private care home were much better than they had expected. She argued that expectations of consumers on private care providers were significantly influenced by stigmas and dire stories on bad experiences shared or made up by the media.

The above case shows that attitudes towards the private sector and care workers can be influenced by personal experience, stigmas, the mass media, and many other factors. In the context of rapid marketisation, increasing interactions between care recipients and care providers lead to changes in public attitudes towards the marketisation process and the market. Behaviours of care providers are also shifting when their involvement in the care market and interactions with other stakeholders are expanding. In turn, changes in public attitudes towards the care market and their decisions to purchase care services influence the further development of the care market. Specifically, the increasing willingness to employ care workers in older people's own homes will improve the general acceptance level of private care providers and the marketisation.

In the meantime, the risks of being heavily dependent on the care market underlie the marketisation process. Some government officials that participated in my study worried that the market may not be a reliable source for older people. If care providers hold significant power in the care market, service users might be in a vulnerable position in practice. My fieldwork data suggest that at least most large for-profit care agencies have the ambition to gain the power for setting up standards of pricing and service for the entire home care industry once they get a large enough share in the market. Owners and managers of large for-profit agencies claimed that they are trying to get more power among providers so as to establish service standards with good quality. However, local care agencies and government officials did not believe these arguments and indicated potential threats from the dominant status of a small number of monopolistic care providers. If one large for-profit care chain dominates, its monopolistic status will make a difference in choosing consumers or "squeeze" small-scale providers out of the market (Hardy and Wistow, 1998) with unhealthy

competition (e.g. decreasing prices to an unreasonable level to bankrupt smaller agencies before raising the price to gain more profits).

From the macro perspective, when a substantial proportion of the Chinese population relies heavily on the care market, if dominant providers suddenly drop out (no matter the reason), the care system will be challenged or even destroyed by lack of supply. Currently, the Chinese government has strong power in the quasi-market (see Section 8.2.3). The role of the state is influential in setting up the service fee level (at least for state-paid services) and controlling the entry to the care market. The balance between each sector in the care diamonds has influential impacts on older people's wellbeing, which calls for more efforts from the state to monitor the care market during the marketisation process.

### *Conclusion*

This chapter has critically analysed three themes arising from the findings: policy implementation gap, shifting dynamics of the care diamonds, and re-conceptualisation of ageing and care in the marketisation context. First, the discussion started with analysis on the distinct policy process in terms of the marketisation of care in urban China and the embedded policy implementation gap. It has explored the hierarchy and power balance of the policy-making and implementation and barriers at the practice level and policy-making level.

Second, the application of market mechanisms leads to changes in the shapes and implications of care diamonds. This chapter has drawn the care diamonds in urban China in two dimensions: care provision and finance. For the former, the family care gradually decreases; the market and the community has become much more active since 2010; while the state is pulling out. Connections and trade-offs between these four sectors have increased in the care provision dimension. For the latter, the state and the family grow to be a bit more substantial, while the market and the community get a subtle increase. Shapes of the care diamonds and the trade-offs between each sector in the finance dimension have no substantial changes; however, critical changes in the composition of each sector and the diamond have been identified. Besides, the regulation dimension remains exclusively inclined

to the state sector, so this chapter has discussed the dominant role of the state in multiple aspects in the marketisation context.

Third, this chapter has suggested that sensitive terms like “ageing” and “old-age dependency” need to be re-conceptualised and applied with discretion. The understanding of old-age dependency on the state and the family have been examined, in the context of the high-level self-support and intergenerational support and growing optimism in terms of the market opportunities in urban China. Considering the attitudes towards the marketisation of care, this chapter has argued that care providers and local government officials generally take the “marketisation” as an undebatable macro idea for granted while critiqued specific outcomes of the process. In a dynamic process, the marketisation path and the attitudes towards the process have influences and counter-influences over each other. Risks of being heavily dependent on the care market have been demonstrated as well.

## Chapter 9 Conclusion

---

### *Introduction*

In relation to the research objective to explore the process of the marketisation of care for older people in urban China, this thesis has examined the central position of home care in the Chinese care regime and the rationale behind it; how marketisation processes have been applied; impacts on practice and the care regime; the policy process and policy implementation gap; and how to re-conceptualise ageing and care in the marketisation context. This concluding chapter begins with a summary of the key findings of the thesis to highlight its original contributions to the theoretical and empirical knowledge of the marketisation of care in urban China. It then turns to theoretical contributions of this thesis on the marketisation of the informal care sector in the international context. This chapter also provides implications for care policy and practice on the improvement of the regulatory framework, marketisation with regard to geographical disparities, and filial obligation in the marketisation context. Based on the findings and discussions in the preceding parts, this chapter concludes with suggestions for future research.

### *9.1 Key Findings of the Thesis*

Literature relating to the marketisation of care is overwhelmingly focused on Europe, based on decades of European experience in developing care markets and their representative care regimes (see Chapter 2). The value of this thesis is that it provides empirical evidence in terms of processes and outcomes of the marketisation of care in urban China, focusing on:

- 1) the central position of home care in the care system (see Chapter 5);
- 2) care for older people in urban China turning to a quasi-market by applying marketisation processes (see Chapter 6);
- 3) distinctive outcomes of the marketisation of care in urban China (see Chapter 7).

Emphasising persistent cultural norms regarding family support in the changing socio-economic context, Chapter 5 has demonstrated the rationale behind the marketisation of home care. Home care accords with the family-centred sociocultural norms and matches



preferences of the state and older people and their families, based on the assumption that home care helps save money from the pragmatic perspective and respects the family-centred culture from the ideological perspective. Policies in terms of developing the home care market are evidently employed in China. I have also investigated the value of the market as a supplement or alternative to families in home care practice, and the increasing involvement of the volunteer support and community function branches.

Chapter 6 has clarified processes of the marketisation of care applied in Shanghai and identified approaches of the quasi-market and the relationships between the state and the market. Three quasi-market models (i.e. the state-controlled model, the limited competition model, and the free market model) have been identified based on different state-market relations and competition levels between care providers. Processes and rationales of how each model were adopted have been illustrated with empirical examples and interpretations of the interview data.

Chapter 7 has shown outcomes of the marketisation process in the field of care for older people in urban China. The crude efficiency is representative in the marketisation process, which allocates more attention to the increase of the care provision supply than care quality. The competition is unequal between care providers due to the preferences and interference of local governments in the commissioning, operating and monitoring process of care schemes. Both for-profit and not-for-profit care providers compete in the care market with dispute surrounding their motivations. Based on the understandings of the legal framework and the accountability of the state in the care field, this chapter suggests that the regulatory system in urban China does not match the rapid marketisation process, which leaves participants in the care market not well-protected.

Based on the findings of this thesis, Chapter 8 has provided an in-depth exploration of the theoretical and empirical understanding of care policy and practice in the marketisation context in urban China. I have discussed the policy process and the policy implementation gap and the rationale behind it. The shifting dynamics of the care diamonds in urban China have been drawn in the dimensions of care provision and finance to show the development of the quasi-market, along with the analysis on the dominant role of the state in the quasi-market.

It has been critically argued that ageing and care need to be re-conceptualised and applied with discretion in the marketisation context. I have examined the understanding of old-age dependency and the high-level self-support and intergenerational support and growing optimism in terms of the market opportunities in urban China. Illustrating changing attitudes of different groups towards the marketisation of care, I have also demonstrated different understandings of the marketisation, influences and counter-influences between the marketisation path and the attitudes, and benefits and risks of the process.

### *9.2 Theoretical Contributions: The Marketisation of the Informal Care Sector*

The thesis not only contributes to the process of marketisation of care in China but also the theoretical discussions in the international context. My arguments on the marketisation of care in China are reinforced by reference to the marketisation process in familial welfare states (e.g. the Mediterranean and East Asian cases). This section highlights common processes in the care systems in urban China and other familial welfare states to allocate my research to the overall picture.

Referring to different models of the marketisation of care in European countries discussed in Chapter 2, the Chinese marketisation process shares similar aspects with the familial model in Mediterranean countries, which emphasises the importance of families and the informal support in the field of care for older people. The main processes of the marketisation of care identified in Mediterranean countries are also applied in urban China, including contracting out services to independent providers, financial support from the state to older people and their families and care providers, and direct purchasing through private funding. Similar strategies of the marketisation of care have been widely employed in Shanghai, such as cash for care, subsidies for multiple groups, and private purchasing (see Chapter 6). Specifically, similarities in policy and practice of the marketisation of care between urban China and Mediterranean countries include older people's preferences on home care and the recognition of their families and the state, increasing involvement of migrant care labour, and development of the informal market.

First, home care is promoted to be a prevailing provision in urban China and other familial welfare states. Like the model of “care worker at home” in Italy (Bettio, Simonazzi and Villa, 2006), care provided by care workers in older people’s own homes is becoming a common choice for families in urban China. Recognising the increasing importance of the market and persistent cultural norms on the emphasis of family support, Chapter 5 has suggested that the marketisation of home care is the main developing direction of care provision for older people in China.

Second, the majority of care labour in all care agencies recruited for my fieldwork were internal migrant workers from rural areas. According to the interview data, rural migrants are the basis for the care labour market in urban China. As discussed in Chapter 2, it is a common situation that international migrant workers from Eastern European countries or other low- and middle-income countries (e.g. Philippines) take jobs in the care sector in Western European countries (Bettio, Simonazzi and Villa, 2006; Shutes and Chiatti, 2012). Even though the origins of migrant care workers are different, the role of migrants in the care labour market is increasingly important for European countries and urban China.

Last, the informal care market is a common phenomenon in both urban China and other familial welfare states. The informal care market in urban China developed much earlier than the state interventions. Compared to the slow pace of the policy process and the embedded implementation gap (see Chapter 8), changes in the market turn up much more quickly. The procedure of marketisation of home care started from the informal care market with volunteer participation of older people and their families, when the state launched the general “Reform and Opening-Up”. The voluntary development of the informal care market in advance of policy-making and implementation is a key point about the distinctiveness of the Chinese marketisation process. With inadequate monitoring and inspection, the quasi-market in urban China is not well-regulated yet (see Chapter 7). Older people and their families purchase care services or employ care workers in the informal market either for cheaper services or because there are no regulated choices available.

### *9.3 Implications for Care Policy and Practice*

This section discusses implications for care policy and practice in the marketisation process on three topics: first, the regulatory framework in the state-dominated system; second, the marketisation process in consideration of geographical disparities; and third, how to support families under the moral obligation of caring for older people.

#### 9.3.1 Improving the regulatory system of the care market

Chapter 8 has analysed that the state control over the quasi-market is significant, but the state regulation is not well-developed in China. Strong state control includes existing influences and the underlying power. As discussed in Chapter 6, the contracting out process relies heavily on decisions of local authorities, during which care providers are located at a subordinate position for negotiation. The underlying control of the state oversees the commissioning and care delivery process. In the meantime, care providers are kept under pressure to impress local authorities for the undergoing projects and prospective biddings regardless of virtuous or corrupted methods (e.g. improving service quality, bribing government commissioners).

In the marketisation process, designing and practising a regulatory framework is vital to keep the order in the care market and protect different participants. The findings of this thesis suggest that the state has set up preliminary regulations on the admittance into the home care service market, but still has no comprehensive regulatory system (e.g. legal framework, monitoring, inspection, and regulation). As discussed in Chapter 7, “black care agencies” without licences and qualifications widely participate in the home care market, which shows that the Chinese government has not placed a high priority on regulation.

My findings reflect the importance to improve quality of care services and occupational benefits of care workers during the marketisation process. First, care quality is a basic concern of service users and purchasers. Local government officials shared the idea that the quality of home care services has not reached their expectations. It is imperative to inspect and monitor the care delivery for the sake of older people. Second, rights and occupational benefits of care workers are not well-protected. As discussed in Chapter 7, care workers’ rights in the labour

market are at risk without formalised working relationships and regulations. As a persistent problem in the care markets across welfare states, heavy workload, low payment and absence of occupational welfare are significant obstacles for care jobs in urban China. The Chinese government has gradually increased financial investment in care labour training and position subsidies (see Chapter 7), but difficulties in the recruitment and retention of care workers remain or have even become more challenging in recent years.

It is common phenomena that rural migrants are discriminated against for the entitlement of social benefits in the urban labour market (Wang, Guo and Cheng, 2015), because migrant workers get access to the welfare system where they are registered instead of where they work based on the household registration system (*hukou*) (Wong, Li and Song, 2007; Ringen and Ngok, 2017). In this context, care workers (especially rural migrants) usually cannot get full access to the five types of social insurance stated by the Labour Law of China (1995): pensions, medical insurance, unemployment insurance, work injury insurance and maternity insurance. The provision of work-based insurance is a legal requirement for all employers. However, my findings suggest that it was common that most home care agencies did not provide insurance to care workers, and this was not well-inspected by the government. As analysed in Chapter 7, some care providers argued that the provision of three types of social insurance (i.e. medical, unemployment, pension insurance) to care workers was (already) an advantage when competing with other care providers in the recruitment and retention of care labour.

Regarding protecting the legal rights of service recipients, providers and care workers, it is imperative for policymakers to pay more attention to the regulations in the care market. My findings show the necessity to develop the legal framework in the care market, to set up feasible regulations on the admittance of home care agencies and care staffing agencies, to categorise different types of care agency licences for the variety of provision, to inspect and monitor the care delivery, and to make sure care workers can get access to entitled occupational benefits.

9.3.2 The marketisation in consideration of geographical inequalities

“Lacking persistent plan and investment from the state” rather than “budget pressures” is the central problem for developing the care market in Shanghai (see Chapter 8). Referring to the widespread unwillingness of older people to purchase services in the care market (see Chapter 5), the expansion of subsidies to a larger group will attract older people to purchase care services at a more affordable price and boost the development of the care market at the same time. For example, Italy provides “cash to care” to all older people to purchase services or employ care workers. Also, the payment level of subsidies and the number of state-paid home care services (i.e. 20 to 25 hours per month) are not enough for the most disadvantaged older people who cannot afford private payments for extra services. A multi-layer subsidy system with reasonable support levels might involve a bigger group of older people to get access to care services.

Meanwhile, geographical disparities between different areas in China (e.g. economic backgrounds, political management characteristics, and policy priorities) lead to unequal allocation of public funding to older residents (see Chapter 3). When local governments hold funding autonomy, the encouragement on expanding financial support to older people would accelerate the disparities between rich and poor areas. It is notable that older people in rural China encounter more difficulties in getting access to financial resources and care provision than urban residents (see Chapter 3). Similar to many other fields, the marketisation of care in urban areas of coastal provinces is generally quicker and earlier than cities in western inland provinces. When the care market develops in urban China, geographical disparities and inequality between richer and poorer groups threaten the Chinese care system. The disparity and inequality issues need to be taken into account by the Chinese central government when making national and regional care policies.

The marketisation process, in turn, has impacts on the policy-making and implementation in different jurisdictions. There are significant differences in priorities on local authorities’ agendas and their attitudes towards marketisation (see Chapter 8). For example, the Shanghai government is relatively supportive on marketisation in the field of social welfare, while some other local authorities do not give priorities to care for older people or welfare issues. There

are influences and counter-influences on the economic background, the general marketisation level, and the marketisation of care in different jurisdictions. Suggestions made in this thesis are only feasible to developed areas in China, but the proposed process of the marketisation of care in urban China contributes to further discussions on the bigger picture of the care system in China.

### 9.3.3 Filial obligation in the marketisation context

Care practice in China is deeply influenced by the persistent moral obligation of “filial piety” (see Chapter 5). When families turn from direct caring to providing financial and emotional support, other sectors gradually become more engaged in the care arrangements. As discussed in Chapter 8, the dynamics and trade-offs between different sectors (i.e. the state, the market, the family, and the community) are important to facilitate the construction of the care system for older people. Concerning characteristics of the intergenerational support system and emerging obstacles in care practice (see Chapter 8), family support for older people need to be flexible and continually responsive to changing circumstances.

Current Chinese care policies are not only targeted to support older people but also to (morally) encourage their families to take care responsibilities (see Chapter 8); however, families have not been entitled to public support or financial encouragement (see Chapter 5). Increasing pressure on filial responsibility in China has the risk of exhausting families. In the context of the persistent cultural norms on filial obligation and the common situation that families are joint decision makers and purchasers of care, it is important to take families into account in care policies and supporting schemes. Strategies applied in other countries cast light on the encouragement of familial caregivers in China, such as the reduction of social security contribution in the UK and Sweden and subsidies to informal caregivers or adult children who live together with older parents to encourage and support families in caring for older people in Singapore and Hong Kong (see Chapter 2).

In addition to the market, the community is significantly involved in care provision for older people, especially for those disadvantaged groups (see Chapter 5). Local authorities in Shanghai have assigned daily check-up duties to community officials and encouraged the neighbour volunteer system, which has established a basic support network for those older

people who are living alone. However, the workload of community officials is too heavy to cover a large amount of visiting needs in each jurisdiction, so their check-ups are superficial, usually only aimed at making sure older residents are alive and still able to live alone. Neighbour volunteers sometimes provide essential support to older people, but the relationship between volunteers and older people is heavily influenced by personal and informal factors instead of being broadly routinised. The persistence and effectiveness of these community support schemes are questioned without sufficient funding support, human resources, systematic training for volunteers, and relevant welfare support to young-old volunteers who offer help to the old-old group.

The market provides a chance for families to take filial obligation by purchasing care services for older people when they are not available for direct care. The involvement of older people and families in the care market have influences and counter-influences on public attitudes towards the marketisation and independent providers (see Chapter 8). In general, the comments on care services and care agencies become more positive on the marketisation trend when compared to the highly stigmatised period for the private sector. This provides one feasible “dualisation” way that high and middle-income groups could purchase more services in the care market based on their own incomes, while disadvantaged people could rely more on the state and the community. Yet, the marketisation of care unavoidably leads to a challenge to the supremacy of equality over quality in the socialist context in China (see Chapter 8), which is a dilemma embedded in China’s market-oriented reforms.

#### *9.4 Strengths, Limitations & Implications for Future Research*

Examining the marketisation of care in urban China, this thesis provides an in-depth exploration of characteristics and pathways of care for older people, an analysis of the marketisation processes and outcomes, and contributes to theoretical discussions in the global context (see Section 9.2) with further implications for policy and practice in urban China (see Section 9.3). The qualitative research journey gave me an opportunity to investigate the emerging quasi-market in the field of care for older people through the representative marketisation case in Shanghai. My refined knowledge about the shifting Chinese care regime and its marketisation process is built on valuable information collected from fieldwork in



Shanghai and abundant documentary data, which are not involved in existing research nor have been systematically analysed before. Informative experiences and views of participants in the care market and theoretical and empirical studies in other countries support my findings and discussions and allow me to refer the Chinese case to the wider context.

Yet, this thesis is not without limitations. First, in addition to the qualitative exploration, big data relating to the care market (e.g. service, finance, labour) is important for the analysis of the marketisation process, which unfortunately is not included in this thesis. It could enhance the validity of my arguments about the financing dimension of the care diamond if first-hand data collection on influential factors in the care market were included (e.g. expenditure of local governments in the field of care for older people, care labour statistics in sampled care agencies). Also, the secondary analysis could be under-taken when the governments or statistic institutions have conducted and released relevant data. Large-scale statistics on the care market and the labour market could provide valuable data for future research.

Second, in the context of the rapid marketisation process across China, diverse trial schemes and projects are conducted by local governments while market mechanisms are voluntarily applied by service users and care providers. The fieldwork case location, Shanghai, is a representative case for research on the topic of marketisation (see Chapter 4). Yet, other big cities have influential and distinctive models of marketisation, while cases in smaller cities could also contribute to the understanding of the comprehensive marketisation process in urban China. Referring to geographical differences and diversity at the local level, the process of marketisation of care and quasi-market models proposed by this thesis cannot be simply generalised to other areas. Instead, it is worth conducting research in different cities to refine the findings of this thesis and provide a model of the marketisation of care in China. The case in smaller cities in inland (generally less developed) provinces might be more likely to be similar to the old model in Shanghai several years ago; future research may draw the longitudinal and geographical changes of the marketisation of care.

Last, this thesis contributes an original exploration of the marketisation of care in urban China. The care system in China is double-tracked in rural and urban areas but still has strong connections between areas. The separate analysis in urban and rural areas is a temporary

expedient based on the disparate care system, which could be compared or combined in future research. Meanwhile, there is lots of research holding a negative perspective on the prospect of increasing disparities between rural and urban areas. It has been realised that rural older people are more vulnerable than urban residents in terms of care provision and financial support. This thesis also suggests that disparities between the rural and urban care system can be treated from a more positive perspective. For example, the migrant outflow from rural areas not only have negative impacts on care for “left-behind” older people, but also positive influences in terms of financial support from migrant workers to their families who remain living in rural areas and their impressive contributions to the marketisation process in urban areas. Future research could explore the comprehensive influence of marketisation on the entire care system in China.

## References

- ALBERTINI, M. & PAVOLINI, E. 2017. Unequal Inequalities: The Stratification of the Use of Formal Care Among Older Europeans. *The journals of gerontology. Series B, Psychological sciences and social sciences*, 72, 510.
- ANTTONEN, A. & SIPILÄ, J. 1996. European Social Care Services: Is it Possible to Identify Models? *Journal of European Social Policy*, 6, 87-110.
- ARKSEY, H. & GLENDINNING, C. 2007. Informal Welfare. In: POWELL, M. (ed.) *Understanding the Mixed Economy of Welfare*. Bristol: The Policy Press.
- ARONSON, J. & NEYSMITH, S. M. 1997. The Retreat of the State and Long-Term Care Provision: Implications for Frail Elderly People, Unpaid Family Carers and Paid Home Care Workers. *Studies in Political Economy*, 53, 37-66.
- BASTEN, S. 2013. Redefining "Old Age" and "Dependency" in East Asia: Is "Prospective Aging" A More Helpful Concept? *Asian Social Work and Policy Review*, 7, 242-248.
- BERG, B. L. 2007. *Qualitative Research Methods for the Social Sciences*, London, Pearson Education Allyn & Bacon.
- BETTIO, F. & PLANTENGA, J. 2004. Comparing Care Regimes in Europe. *Feminist Economics*, 10, 85-113.
- BETTIO, F., SIMONAZZI, A. & VILLA, P. 2006. Change in Care Regimes and Female Migration: The 'Care Drain' in the Mediterranean. *Journal of European Social Policy*, 16, 271-285.
- BODE, I., CHAMPETIER, B. & CHARTRAND, S. 2013. Embedded Marketization as Transnational Path Departure. Assessing Recent Change in Home Care Systems Comparatively. *Comparative Sociology*, 12, 821-850.
- BODE, I., GARDIN, L. & NYSSSENS, M. 2011. Quasi-Marketisation in Domiciliary Care: Varied Patterns, Similar Problems? *International Journal of Sociology and Social Policy*, 31, 222-235.
- BOLTON, S. C. & WIBBERLEY, G. 2014. Domiciliary Care: The Formal and Informal Labour Process. *Sociology-the Journal of the British Sociological Association*, 48, 682-697.
- BOWLES, S. & GINTIS, H. 2002. The Inheritance of Inequality. *Journal of Economic Perspectives*, 16, 3-30.
- BOYATZIS, R. E. 1998. *Transforming Qualitative Information: Thematic Analysis and Code Development*, Thousand Oaks; London; New Delhi, Sage.

- BRAUN, V. & CLARKE, V. 2006. Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*, 3, 77-101.
- BRENNAN, D., CASS, B., HIMMELWEIT, S. & SZEBEHELY, M. 2012. The Marketisation of Care: Rationales and Consequences in Nordic and Liberal Care Regimes. *Journal of European Social Policy*, 22, 377-391.
- BRYMAN, A. 2007. Barriers to Integrating Quantitative and Qualitative Research. *Journal of Mixed Methods Research*, 1, 8-22.
- BRYMAN, A. 2012. *Social Research Methods*, Oxford, Oxford University Press.
- BURAU, V., THEOBALD, H. & BLANK, R. H. 2007. *Governing Homecare. A Cross-National Comparison*, Cheltenham, Edward Elgar.
- CAI, F., GILES, J., O'KEEFE, P. & WANG, D. 2012. *The Elderly and Old Age Support in Rural China: Challenges and Prospects*, Washington, DC, World Bank.
- CALLON, M. 1998. Introduction: the embeddedness of economic markets in economics. *Sociological Review Monograph series*, 46, 1-57.
- CENTRAL COMMITTEE OF THE COMMUNIST PARTY OF CHINA 1987. Report on 13th Communist Party of China National Congress. Beijing: Central Committee of the Communist Party of China.
- CENTRAL COMMITTEE OF THE COMMUNIST PARTY OF CHINA 2012. Report on 18th Communist Party of China National Congress. Beijing.
- CENTRAL COMMITTEE OF THE COMMUNIST PARTY OF CHINA 2013. Decision on Issues of Comprehensively Deepen Reforms by the Central Committee of the Communist Party of China. Beijing.
- CENTRAL COMMITTEE OF THE COMMUNIST PARTY OF CHINA & STATE COUNCIL 2000. Reinforce Population and Family Planning to Maintain the Low Fertility Rate. [http://www.gov.cn/gongbao/content/2000/content\\_60154.htm](http://www.gov.cn/gongbao/content/2000/content_60154.htm) ed. Beijing.
- CENTRAL COMMITTEE OF THE COMMUNIST PARTY OF CHINA & STATE COUNCIL 2007. Strengthen the Population and Family Planning and Address the Population Problem in an Integrated Manner. [http://www.gov.cn/gongbao/content/2007/content\\_534194.htm](http://www.gov.cn/gongbao/content/2007/content_534194.htm) ed. Beijing.
- CERNA, L. 2013. The Nature of Policy Change and Implementation: A Review of Different Theoretical Approaches. OECD.

- CHAN, K. W., LIU, T. & YANG, Y. 1999. Hukou and Non-Hukou Migrations in China: Comparisons and Contrasts. *International Journal of Population Geography*, 5, 425-448.
- CHAN, P. C. H. 2017. Civil Mediation in Imperial, Republican and Modern-Day China: Historical and Cultural Norms Under the Traditional Chinese Legal Order. *Legal History Review*, 85, 577-602.
- CHAN, R. K. H., TAKAHASHI, M. & WANG, L. L.-R. 2010. *Risk and Public Policy in East Asia*, Farnham, Ashgate.
- CHANG, H., DONG, X.-Y. & MACPHAIL, F. 2011. Labor Migration and Time Use Patterns of the Left-Behind Children and Elderly in Rural China. *World Development*, 39, 2199.
- CHEN, H., WONG, Y.-C., ZENG, Q. & JUHA, H. 2013. Trapped in Poverty? A Study of the Dibao Programme in Shanghai. *China Journal of Social Work*, 6, 1-17.
- CHEN, J. & JORDAN, L. P. 2018. Intergenerational Support and Life Satisfaction of Young-, Old- and Oldest-Old Adults in China. *Aging & Mental Health*, 22, 412-420.
- CHEN, W. & HUANG, H. 2012. Social Work for the Elderly from a Critical Perspective: A Reflection upon the Rights and Interests of the Elder Service Users in the Home- and Community- Based Services for the Elderly. *Social Sciences in Nanjing*, 70-77.
- CHENG, J. Y. S. 2014. Institutions, Perceptions and Social Policy-Making of Chinese Local Governments: A Case Study of Medical Insurance Policy Reforms in Dongguan. *Journal of Asian Public Policy*, 7, 13.
- CHINA 1980. Marriage Law of People's the Republic of China. *In: NATIONAL PEOPLE'S CONGRESS* (ed.). Beijing.
- CHINA 1982. Constitution of the People's Republic of China. *In: NATIONAL PEOPLE'S CONGRESS* (ed.). Beijing.
- CHINA 1995. Labour Law of the People's Republic of China. *In: NATIONAL PEOPLE'S CONGRESS* (ed.). Beijing.
- CHINA 2010. Social Insurance Law of the People's Republic of China. *In: NATIONAL PEOPLE'S CONGRESS* (ed.). Beijing.
- CHINA 2015. Law on Protection of the Rights and Interests of Older People of the People's Republic of China. *In: NATIONAL PEOPLE'S CONGRESS* (ed.). Beijing.
- CHINA 2016. Charity Law of the People's Republic of China. *In: NATIONAL PEOPLE'S CONGRESS*

- (ed.). Beijing.
- CHINA 2016. Law of the People's Republic of China on Population and Family Planning (Revised). In: NATIONAL PEOPLE'S CONGRESS (ed.). Beijing.
- CHINA NATIONAL WORKING COMMISSION ON AGEING 2008. Guidelines for Comprehensively Promoting Home Care Services. Beijing.
- CHINA NATIONAL WORKING COMMISSION ON AGEING 2010. The Sampling Survey of the Aged Population in Urban/Rural China 2010. Beijing.
- CHINA PHILANTHROPY RESEARCH INSTITUTE 2017. 2017 Annual Report on Care for Older People in China. Beijing: China Philanthropy Research Institute at Beijing Normal University.
- CHIU, R. L. H. 2001. Commodification of Housing with Chinese Characteristics. *Policy Studies Review*, 18, 75-95.
- CHON, Y. 2015. An Exploratory Qualitative Study on Relationships between Older People and Home Care Workers in South Korea: The View from Family Carers and Service Providers. *Ageing & Society*, 35, 629-652.
- CIVIL AFFAIRS BUREAU IN SHANGHAI 2000. Purchasing Public Services by Shanghai Government. Shanghai.
- CLAASSEN, R. 2011. The Commodification of Care. *Hypatia*, 26, 43-64.
- COLLYER, F. & WHITE, K. 2011. Introduction The Privatisation of Medicare and the National Health Service, and the Global Marketisation of Healthcare Systems. *Health Sociology Review*, 20, 238-244.
- CRAM, L. 1997. *Policy-Making in the European Union: Conceptual Lenses and the Integration Process*, London, Routledge.
- CRESWELL, J. W. 2014. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, Los Angeles, SAGE Publications.
- DALY, M. & LEWIS, J. 2000. The Concept of Social Care and the Analysis of Contemporary Welfare States. *British Journal of Sociology*, 51, 281-298.
- DING, J. 2013. The Home Care Service: Recognizing Mistakes, Rational Principles and Perfecting Measures. *Journal of Renmin University in China*, 27, 20-26.
- DIVISION OF SOCIAL SECURITY OF MINISTRY OF FINANCE OF CHINA 2011. *Reforms and Development of Social Security from Financing Perspective*, Beijing, China Financial &

- Economic Publication House.
- DRAKEFORD, M. 2007. Private Welfare. In: POWELL, M. (ed.) *Understanding the Mixed Economy of Welfare*. Bristol: The Policy Press.
- DU, P. & TU, P. 2000. Population Ageing and Old Age Security. In: PENG, X. & GUO, Z. (eds.) *The Changing Population of China*. Oxford: Blackwell Publishers.
- ECONOMIST INTELLIGENCE UNIT 2014. China Healthy Province Index. The Economist Intelligence Unit.
- EIKA, K. H. 2009. The Challenge of Obtaining Quality Care: Limited Consumer Sovereignty in Human Services. *Feminist Economics*, 15, 113-137.
- ESPING-ANDERSEN, G. 1990. *The Three Worlds of Welfare Capitalism*, Cambridge, Polity Press.
- EVERS, A. & SVETLIK, I. 1993. *Balancing Pluralism: New Welfare Mixes in Care for the Elderly*, Aldershot, Avebury.
- FAN, G., WANG, X. & ZHU, H. 2011. *NERI Index of Marketization of China's Provinces 2011 Report*, Beijing, Economic Science Press.
- FAN, W., QI, J., XUE, M., ZHENG, Q. & GAN, X. 2010. Government Purchases of Public Services from CSOs on the Home-Based Aged-Care Services: A Case of Gulou District in Nanjing. *Scientific Decision Making (China)*, 19-30.
- FEDERAL STATISTICAL OFFICE OF GERMANY 2015. Germany's Population by 2060 - Results of the 13th Coordinated Population Projection. Federal Statistical Office of Germany.
- FENG, J. 2004. Welfare Analysis of China's Pension System. *Economic Research Journal (China)*, 55-63.
- FENG, Z., LIU, C., GUAN, X. & MOR, V. 2012. China's Rapidly Aging Population Creates Policy Challenges In Shaping A Viable Long-Term Care System. *Health Affairs*, 31, 2764-2773.
- FERNÁNDEZ, J.-L., FORDER, J., TRUKESCHITZ, B., ROKOSOVÁ, M. & MCDAID, D. 2009. How Can European States Design Efficient, Equitable and Sustainable Funding Systems for Long-Term Care for Older People? In: PERMANAND, G. (ed.) *WHO Regional Office for Europe and European Observatory on Health Systems and Policies Copenhagen Ø*, Denmark: World Health Organization
- FINCH, J. 1989. *Family Obligations and Social Change*, Cambridge, Polity Press.
- FORDER, J. & ALLAN, S. 2014. The Impact of Competition on Quality and Prices in the English

- Care Homes Market. *Journal of Health Economics*, 34, 73-83.
- FORDER, J., KNAPP, M., HARDY, B., KENDALL, J., MATOSEVIC, T. & WARE, P. 2004. Prices, Contracts and Motivations: Institutional Arrangements in Domiciliary Care. *Policy & Politics*, 32, 207-222.
- FORDER, J., KNAPP, M. & WISTOW, G. 1996. Competition in the Mixed Economy of Care. *Journal of Social Policy*, 25, 201-221.
- FRANCIS, J. J., JOHNSTON, M., ROBERTSON, C., GLIDEWELL, L., ENTWISTLE, V., ECCLES, M. P. & GRIMSHAW, J. M. 2010. What is an Adequate Sample Size? Operationalising Data Saturation for Theory-Based Interview Studies. *Psychology & Health*, 25, 1229-1245.
- GLENDINNING, C. 2012. Home Care in England: Markets in the Context of Under-Funding. *Health & Social Care in the Community*, 20, 292-299.
- GOLD, T. B., HURST, W. J., WON, J. & QIANG, L. 2009. *Laid-Off Workers in a Workers' State: Unemployment with Chinese Characteristics*, Basingstoke, Palgrave Macmillan.
- GORI, C., CHIATTI, C. & DI ROSA, M. The Reform of the Italian Cash-For-Care System in Times of Economic Recession. An Example of Evidence-Based Users' Lobby. ILPN International Conference, 2012 London. ILPN.
- GORNITZKA, A., KOGAN, M. & AMERAL, A. 2005. *Reform and Change in Higher Education: Analysing Policy Implementation*, Dordrecht, Springer.
- GOTT, M., SMALL, N., BARNES, S., PAYNE, S. & SEAMARK, D. 2008. Older People's Views of A Good Death in Heart Failure: Implications for Palliative Care Provision. *Social Science & Medicine*, 67, 1113-1121.
- GREENER, I. 2008. Markets in the Public Sector: When Do They Work, and What Do We Do When They Don't? *Policy and Politics*, 36, 93-108.
- GRUNDY, E. & HENRETTA, J. C. 2006. Between Elderly Parents and Adult Children: A New Look at the Intergenerational Care Provided by the Sandwich Generation. *Ageing and Society*, 26, 707-722.
- GUAN, X. 2000. China's Social Policy: Reform and Development in the Context of Marketization and Globalization. *Social Policy & Administration*, 34, 115-130.
- GUO, L., ZHANG, J., MA, W., SHA, X., YI, X., ZHANG, B., WANG, C. & WANG, S. 2015. Offspring Caregivers' Depression Affected by Intergenerational Disagreements on Preferred



- Living Arrangement for the Elderly: A Phenomena with Chinese Characteristic. *Archives of Gerontology and Geriatrics*, 61, 363-370.
- GUO, Z. & LI, D. 2010. Analysis on Shanghai Population Changes in Recent Years. *China Journal of Population Science*, 13-22.
- HARDY, B. & WISTOW, G. 1998. Securing Quality Through Contracts? The Development of Quasi-Markets for Social Care in Britain. *Australian Journal of Public Administration*, 57, 25-35.
- HE, C., CHEN, T., MAO, X. & ZHOU, Y. 2016. Economic Transition, Urbanization and Population Redistribution in China. *Habitat International*, 51, 39-47.
- HILL, M. 2007. The Mixed Economy of Welfare: A Comparative Perspective. In: POWELL, M. (ed.) *Understanding the Mixed Economy of Welfare*. Bristol: The policy press.
- HILL, M. & HUPE, P. 2003. The Multi-Layer Problem in Implementation Research. *Public Management Review*, 5, 471-490.
- HILL, M. J. 1997. *The Policy Process in the Modern State*, London, Prentice Hall.
- HILL, M. J. 2013. *The Public Policy Process*, Harlow, Pearson.
- HILL, M. J. & HUPE, P. L. 2014. *Implementing Public Policy: An Introduction to the Study of Operational Governance*, Los Angeles: SAGE.
- HOCKEY, J. L. & JAMES, A. 1993. *Growing up and Growing Old: Ageing and Dependency in the Life Course*, London, SAGE.
- HOGWOOD, B. W. & GUNN, L. A. 1984. *Policy Analysis for the Real World*, Oxford, Oxford University Press.
- HOLZMANN, R., MACARTHUR, I. & SIN, Y. 2000. Pension Systems in East Asia and the Pacific: Challenges and Opportunities. *Social Protection Discussion Paper Series*. Washington, DC: World Bank.
- HONG KONG GOVERNMENT 1999. LCQ18: Dependent Parent or Grandparent Allowances. <http://www.info.gov.hk/gia/general/199906/16/0616128.htm> ed. Hong Kong: HK Special Administrative Region Government.
- HONG KONG GOVERNMENT. 2000. *Deduction for Elderly Residential Care Expenses* [Online]. Hong Kong: Hong Kong Government. Available: <https://www.gov.hk/en/residents/taxes/salaries/allowances/deductions/elderly.htm> [Accessed 19 November 2017].

- HORIZON RESEARCH CONSULTANCY 2010. Chinese Residents' Life Quality Index Survey. Shanghai: Horizon Research Consultancy.
- HOUSE & DEVELOPMENT BOARD OF SINGAPORE. 2015. *Living With/ Near Parents or Married Child* [Online]. Singapore. Available: <http://www.hdb.gov.sg/cs/infoweb/residential/buying-a-flat/resale/living-with-near-parents-or-married-child> [Accessed 19 November 2017].
- HU, N. & YANG, Y. 2012. The Real Old-Age Dependency Ratio and the Inadequacy of Public Pension Finance in China. *Journal of Population Ageing*, 5, 193-209.
- HU, Z. & PENG, X. 2012. China's Old Age Support System in the Perspective of Developmental Welfare. *Journal of Public Management*, 9, 60-70.
- HUPE, P. L. & HILL, M. J. 2016. 'And the Rest Is Implementation.' Comparing Approaches to What Happens in Policy Processes Beyond Great Expectations. *Public Policy and Administration*, 31, 103-121.
- IZUHARA, M. 2003. Social Inequality under a New Social Contract: Long-term Care in Japan. *Social Policy & Administration*, 37, 395-410.
- JING, Y. 2009. Action on Ageing in China: A Multi-Perspective Analysis. *Fudan Journal of the Humanities and Social Sciences*, 2, 83-103.
- JING, Y. & CHEN, R. 2009. The Development and Management Innovation of Home Care System in China: A Perspective of Coordination. *Fudan Journal (Social Sciences)*, 5, 133-140.
- KNAPP, M., HARDY, B. & FORDER, J. 2001. Commissioning for Quality: Ten Years of Social Care Markets in England. *Journal of Social Policy*, 30, 283-306.
- KNIGHT, J., LI, S. & SONG, L. 2006. The Rural-Urban Divide and the Evolution of Political Economy in China. In: BOYCE, J., CULLENBERG, S., PATTANAIK, P. & POLLIN, R. (eds.) *Human Development in the Era of Globalisation. Essays in Honor of Keith B. Griffin*. Cheltenham, UK Northampton, USA: Edward Elgar.
- KOSTKA, G. & HOBBS, W. 2012. Local Energy Efficiency Policy Implementation in China: Bridging the Gap between National Priorities and Local Interests. 211, 765-785.
- KVALE, S. & BRINKMANN, S. 2009. *InterViews: Learning the Craft of Qualitative Research Interviewing*, London, SAGE.
- LAND, H. & HIMMELWEIT, S. 2010. Who Cares: Who Pays? a Report on Personalisation in

- Social Care. London: UNISON.
- LAND, H. & ROSE, H. 1985. Compulsory Altruism for Some or an Altruistic Society for All? *In*: BEAN, P., FERRIS, J. & WHYNES, D. K. (eds.) *In Defence of Welfare*. London: Tavistock.
- LAVELY, W. & REN, X. 1992. Patrilocality and Early Marital Co-Residence in Rural China, 1955-85. *China Quarterly*, 130, 378-391.
- LE GRAND, J. 1991. Quasi-Markets and Social Policy. *The Economic Journal*, 101, 1256.
- LE GRAND, J. & BARTLETT, W. 1993. *Quasi-markets and social policy*, Basingstoke, Macmillan.
- LEECE, J. 2004. Money Talks, but What Does it Say? Direct Payments and the Commodification of Care. *Practice*, 16, 211-221.
- LEICHSENRING, K., WINKELMANN, J. & RODRIGUES, R. 2014. To Make or to Buy Long-term Care III: Quality Assurance to Avoid Market-failure. *In*: VANHUYSSE, P. (ed.) *Policy Briefs*. Vienna: Centre for Social Welfare Policy and Research.
- LEWIS, J. 1993. Developing the Mixed Economy of Care - Emerging for Voluntary Organizations. *Journal of Social Policy*, 22, 173-192.
- LEWIS, J. 1995. Family Provision of Health and Welfare in the Mixed Economy of Care in the Late 19th and 20th Centuries. *Social History of Medicine*, 8, 1-16.
- LEWIS, J. & NICHOLLS, C. M. 2014. Design Issues. *In*: RITCHIE, J., LEWIS, J., NICHOLLS, C. M. & ORMSTON, R. (eds.) *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. London: Sage.
- LEWIS, J. & WEST, A. 2014. Re-Shaping Social Care Services for Older People in England: Policy Development and the Problem of Achieving 'Good Care'. *Journal of Social Policy*, 43, 1-18.
- LI, C. 2013a. Analysis of the Government's Role in the Marketization of Public Service Based on European and Chinese Cases. *2013 International Conference on Management Science & Engineering (20th)*. Harbin, China: IEEE.
- LI, J. 2013b. Reasons, Models, and Strategies of Purchasing Public Services by the State. *Reform (China)*, 13.
- LI, L. C. 2010. Central-Local Relations in the People's Republic of China: Trends, Processes and Impacts for Policy Implementation. *Public Administration and Development*, 30, 177-190.
- LI, S. M. & SIU, Y. M. 1997. A Comparative Study of Permanent and Temporary Migration in

- China: The Case of Dongguan and Meizhou, Guangdong Province. *International Journal of Population Geography*, 3, 63-82.
- LI, Y. & PENG, X. 2000. Age and Sex Structures. In: PENG, X. & GUO, Z. (eds.) *The changing population of China*. Oxford: Blackwell Publishers.
- LIEBERTHAL, K. 1997. *China's Governing System and its Impact on Environmental Policy Implementation*, Washington, DC, Woodrow Wilson.
- LIN, W. 2016. Community Service Provision for the Elderly under the Context of Contracting Out in Guangzhou of China. *Ageing International*, 41, 427-441.
- LINDBLOM, C. E. 1959. The Science of "Muddling Through". *Public Administration Review*, 19, 79-88.
- LINDBLOM, C. E. & WOODHOUSE, E. J. 1993. *The Policy-Making Process*, Englewood Cliffs, N.J., Prentice Hall.
- LIU, S. & ZHUANG, H. 2012. The Current Situation of Care Labour in Changde and Policy Implications. *Chinese Journal of Geriatric Care*, 55-56.
- LIU, X. 2012. The Situation and Path Selection of China's Social Support System for the Elderly. *Population Research*, 36, 104-112.
- LIU, X. 2014. Study on the Financing Gap and Sustainability of China's Pension System. *China Industrial Economics*, 318, 25-37.
- LLOYD, L. 2012. *Health and Care in Ageing Societies: A New International Approach*, Bristol, Policy Press.
- LO, K. 2014. China's Low-Carbon City Initiatives: The Implementation Gap and the Limits of the Target Responsibility System. *Habitat International*, 42, 236-244.
- LOWRIE, A. & HEMSLEY-BROWN, J. 2011. This Thing Called Marketisation. *Journal of Marketing Management*, 27, 1081-1086.
- LU, B. 2014. Rural Long Term Care Policy for China: Evidence from CHARLs. *International Long-term care Policy Network (ILPN) International Conference*. London: ILPN.
- LU, B. & YANG, M. Long Term Care and Its Solutions in China. ILPN International Conference, 2014 London. ILPN.
- LUND, B. 2007. State Welfare. In: POWELL, M. (ed.) *Understanding the Mixed Economy of Welfare*. Bristol: The Policy Press.
- MA, Z. & ZHOU, G. 2011. Supports for the Elderly under the Market Transition in China.

- Population Research*, 35, 17-38.
- MATOSEVIC, T., KNAPP, M., GRAND, J. L. & FERNANDEZ, J.-L. 2011. Changes over Time: The Motivations of Independent-Sector Care-Home Managers and Owners in England Between 1994 and 2003. *Ageing and Society*, 31, 1389-1405.
- MCKAY, S., MORO, D., TEASDALE, S. & CLIFFORD, D. 2015. The Marketization of Charities in England and Wales. *International Society for Third-sector Research*, 26, 336-354.
- MEANS, R., SMITH, R. & MORBEY, H. 2002. *From Community Care to Market Care? : The Development of Welfare Services for Older People, 1971-1993*, Bristol, Policy Press.
- MENG, X. 2000. *Labour Market Reform in China*, Cambridge, Cambridge University Press.
- MI, H. A Series of Surveys About Ltc in China Conducted by Zhejiang University. ILPN International Conference, 2014 London. ILPN.
- MINISTRY OF CIVIL AFFAIRS OF CHINA 2011a. Construction Plan of Social Care for Older People (2011-2015). Beijing.
- MINISTRY OF CIVIL AFFAIRS OF CHINA 2011b. National Civil Affairs Personnel Long-Term Development Plan (2010-2020). Beijing.
- MINISTRY OF CIVIL AFFAIRS OF CHINA 2016. Announcements on the Central Financial Budget Support Trials of Home Care and Community Care for Older People. Beijing.
- MINISTRY OF CIVIL AFFAIRS OF CHINA 2017a. 2016 Statistical Report of the People's Republic of China on the Development of Social Services. Beijing.
- MINISTRY OF CIVIL AFFAIRS OF CHINA 2017b. Reply to the "Proposal on Promoting the Development of Home Care and Community Care". Beijing.
- MINISTRY OF CIVIL AFFAIRS OF CHINA & MINISTRY OF FINANCE OF CHINA 2017. Central Financial Budget Will Support the Trials of Home Care and Community Care for Older People. In: MINISTRY OF CIVIL AFFAIRS OF CHINA & MINISTRY OF FINANCE OF CHINA (eds.). Beijing.
- MINISTRY OF HUMAN RESOURCES AND SOCIAL SECURITY OF CHINA 2018. Interpretations of the Policy of "Opinions of the State Council on Establishing a Unified Basic Pension Insurance System for Urban and Rural Residents". Beijing.
- MOK, K. H., WONG, Y. C. & ZHANG, X. 2009. When Marketisation and Privatisation Clash with Socialist Ideals: Educational Inequality in Urban China. *International Journal of Educational Development*, 29, 505-512.

- MUSZYŃSKA, M. & RAU, R. 2012. The Old-Age Healthy Dependency Ratio in Europe. *Journal of Population Ageing*, 5, 151-162.
- NATIONAL BUREAU OF STATISTICS OF CHINA 2000. *China Statistical Yearbook 2000*, Beijing, China Statistics Press.
- NATIONAL BUREAU OF STATISTICS OF CHINA 2004. *China Statistical Yearbook 2004*, Beijing, China Statistics Press.
- NATIONAL BUREAU OF STATISTICS OF CHINA 2008. *China Statistical Yearbook 2008*, Beijing, China Statistics Press.
- NATIONAL BUREAU OF STATISTICS OF CHINA 2010. China Census 2010. *China Census*. Beijing.
- NATIONAL BUREAU OF STATISTICS OF CHINA 2011. 2010 National Economic and Social Development. Beijing.
- NATIONAL BUREAU OF STATISTICS OF CHINA 2012. *China Statistical Yearbook 2012*, Beijing, China Statistics Press.
- NATIONAL BUREAU OF STATISTICS OF CHINA 2015. *China Statistical Yearbook 2015*, Beijing, China Statistics Press.
- NATIONAL BUREAU OF STATISTICS OF CHINA 2016a. *China Statistical Yearbook 2016*, Beijing, China Statistics Press.
- NATIONAL BUREAU OF STATISTICS OF CHINA 2016b. China 1% Population Sample Survey in 2015. Beijing.
- NATIONAL BUREAU OF STATISTICS OF CHINA 2017a. *China Statistical Yearbook 2017*, Beijing, China Statistics Press.
- NATIONAL BUREAU OF STATISTICS OF CHINA 2017b. Comparative Analysis of Social Expenditure Between China and EU. *The World of Survey and Research*, 4.
- NATIONAL BUREAU OF STATISTICS OF CHINA 2017c. 2016 Rural Migrants Investigation Report. Beijing.
- NATIONAL BUREAU OF STATISTICS OF CHINA 2018. National Economic and Social Development in 2017. Beijing.
- NATIONAL HEALTH AND FAMILY PLANNING COMMISSION 2015. Report on Development of Chinese Family 2015. Beijing.
- NATIONAL HEALTH AND FAMILY PLANNING COMMISSION 2018. The Director of National Health and Family Planning Commission Answered Reporters on the 2017 Birth

- Population. Beijing.
- NETTEN, A., DARTON, R., DAVEY, V., KENDALL, J., KNAPP, M., WILLIAMS, J., FERNÁNDEZ, J.-L. & FORDER, J. 2005. Understanding Public Services and Care Markets. London: King's Fund.
- NG, K.-H. 2011. Review Essay: Prospects for Old-Age Income Security in Hong Kong and Singapore. *Journal of Population Ageing*, 4, 271-293.
- NGOK, K. 2007. Chinese Education Policy in the Context of Decentralization and Marketization: Evolution and Implications. *Asia Pacific Education Review*, 8, 142-157.
- NIELSEN, I., NYLAND, C., SMYTH, R. & ZHU, C. 2005. Marketization and Perceptions of Social Protection in China's Cities. *World Development*, 33, 1759-1781.
- NTSHOE, I. M. 2004. Higher Education and Training Policy and Practice in South Africa: Impacts of Global Privatisation, Quasi-Marketisation and New Managerialism. *International Journal of Educational Development*, 24, 137-154.
- NYSENS, M. 2010. Introduction to the Special Issue The Development of Quasi-Market in Domiciliary Care: A European Perspective. *Annals of Public and Cooperative Economics*, 81, 501-507.
- NYSENS, M., PICCHI, S. & SIMONAZZI, A. 2012. The Process of Marketisation in Home Care and Its Consequences on Welfare Mix: A Comparative Analysis. *2nd International Conference on Evidence-based Policy in Long-term Care*. London: ILPN 2012 conference.
- OCHIAI, E. 2009. Care Diamonds and Welfare Regimes in East and South-East Asian Societies: Bridging Family and Welfare Sociology. *International Journal of Japanese Sociology*, 18, 60-78.
- OECD 2011. International Migration Outlook 2011. Paris: OECD.
- OECD 2018. Social Spending (Indicator). *Social Expenditure Database (SOCX)*. OECD.
- PAVOLINI, E. & RANCI, C. 2008. Restructuring the Welfare State: Reforms in Long-Term Care in Western European Countries. *Journal of European Social Policy*, 18, 246-259.
- PENG, I. 2012. Social and Political Economy of Care in Japan and South Korea. *International Journal of Sociology and Social Policy*, 32, 636-649.
- PENG, X. & GUO, Z. 2000. *The Changing Population of China*, Oxford, Blackwell Publishers.
- PENG, X. & ZHOU, M. 2014. The Psychological Mechanism and Prevention of Environmental

- Group Events. *Social Work (China)*, 30-40.
- PERETTI-WATEL, P. & CONSTANCE, J. 2009. "It's All We Got Left". Why Poor Smokers Are Less Sensitive to Cigarette Price Increases. *International Journal of Environmental Research and Public Health*, 6, 608-621.
- PHILLIPS, D. R. & FENG, Z. 2015. Challenges for the Aging Family in the People's Republic of China. *Canadian Journal on Aging*, 34, 290-304.
- PINDYCK, R. S. & RUBINFELD, D. L. 2013. *Microeconomics*, Boston; London, Pearson.
- POWELL, M. A. 2007. *Understanding the Mixed Economy of Welfare*, Bristol, The Policy Press.
- RAN, R. 2013. Perverse Incentive Structure and Policy Implementation Gap in China's Local Environmental Politics. *Journal of Environmental Policy & Planning*, 15, 17-39.
- RAZAVI, S. 2007. The Political and Social Economy of Care in a Development Context. Geneva: United Nations Institute for Social Development (UNRISD).
- RINGEN, S. & NGOK, K. 2017. What Kind of Welfare State Is Emerging in China? In: YI, I. (ed.) *Towards Universal Health Care in Emerging Economies*. London: Palgrave Macmillan.
- RITCHIE, J., LEWIS, J., MCNAUGHTON NICHOLLS, C. & ORMSTON, R. 2014. *Qualitative Research Practice: A Guide for Social Science Students and Researchers*.
- ROSE, R. & SHIRATORI, R. 1986. *The Welfare State East and West*, Oxford, Oxford University Press.
- SAICH, T. 2000. Negotiating the State: The Development of Social Organizations in China. *The China Quarterly*, 161, 124-141.
- SANDERSON, W. C. & SCHERBOV, S. 2010. Demography. Remeasuring Aging. *Science*, 329, 1287.
- SARACENO, C. 2010. Social Inequalities in Facing Old-Age Dependency: A Bi-Generational Perspective. *Journal of European Social Policy*, 20, 32-44.
- SCHERBOV, S., SANDERSON, W. C. & GIETEL-BASTEN, S. 2016. Better Way to Measure Ageing in East Asia That Takes Life Expectancy into Account. *Australasian Journal on Ageing*, 35, 139-142.
- SCHOFIELD, J. 2001. Time for a Revival? Public Policy Implementation: A Review of the Literature and an Agenda for Future Research. *International Journal of Management Reviews*, 3, 245-263.
- SCHWITER, K. 2013. Aversions to the Commodification of Care: How Young Swiss Adults Plan



- to Organise Their Future Families. *Social and cultural geography*, 14, 500-516.
- SCOTT, I. 2010. *The Policy Process*, Hong Kong, Hong Kong University Press.
- SEALE, C. 1997. Social and Ethical Aspects of Euthanasia: A Review. *Progress in palliative care*, 5, 141-146.
- SHANG, X. & WU, X. 2011. The Care Regime in China: Elder and Child Care. *Journal of Comparative Social Welfare*, 27, 123-131.
- SHANGHAI MUNICIPAL BUREAU OF STATISTICS & SURVEY OFFICE OF THE NATIONAL BUREAU OF STATISTICS IN SHANGHAI 2015. *Shanghai Statistical Yearbook 2015*, Beijing, China Statistics Press.
- SHANGHAI MUNICIPAL STATISTICS BUREAU. 2017. *2017 Shanghai Statistical Yearbook* [Online]. China Statistics Press. Available: <http://tjj.sh.gov.cn/tjnj/nj17.htm?d1=2017tjnj/C0206;> <http://tjj.sh.gov.cn/tjnj/nj17.htm?d1=2017tjnj/C0207.htm>. [Accessed 16th July 2018].
- SHANGHAI MUNICIPAL GOVERNMENT 2014. *Shanghai Yearbook 2014*, Shanghai.
- SHANGHAI MUNICIPAL GOVERNMENT 2016a. Implementation Advice on the Construction of Care Institutions for Older People in the 13th Five-Year Plan Period in Shanghai. Shanghai.
- SHANGHAI MUNICIPAL GOVERNMENT 2016b. The Thirteenth Five-Year Plan of Economic and Social Development of Shanghai. Shanghai.
- SHANGHAI RESEARCH CENTRE ON AGEING 2015. Statistics of Ageing Population and Elder Care in Shanghai in 2014. <http://www.shrca.org.cn/5742.html> ed. Shanghai: Shanghai Research Centre on Ageing.
- SHI, L., SATO, H. & SICULAR, T. 2013. *Rising Inequality in China Challenges to a Harmonious Society*, Cambridge, Cambridge University Press.
- SHUTES, I. & CHIATTI, C. 2012. Migrant Labour and the Marketisation of Care for Older People: The Employment of Migrant Care Workers by Families and Service Providers. *Journal of European Social Policy*, 22, 392-405.
- SOMA, N., YAMASHITA, J. & CHAN, R. K. H. 2011. Comparative Framework for Care Regime Analysis in East Asia. *Journal of Comparative Social Welfare*, 27, 111-121.
- SONG, J. 2014. The Elder Care System of Ageing Cities in Transition Stage: The Case Study in

- Shanghai. *China Economist*, 21-24.
- SPENCER, L., RITCHIE, J., ORMSTON, R., O'CONNOR, W. & BARNARD, M. 2014. Analysis: Principles and Processes. *In*: RITCHIE, J., LEWIS, J., NICHOLLS, C. M. & ORMSTON, R. (eds.) *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. London: Sage.
- STATE COUNCIL OF CHINA 1994. Seven-Year Development Outline on Work Concerning Elderly People in China (1994-2000). *In*: MINISTRY OF CIVIL AFFAIRS, MINISTRY OF LABOUR FORCE & NATIONAL DEVELOPMENT AND REFORM COMMISSION (eds.). Beijing.
- STATE COUNCIL OF CHINA 2000. The Announcement on Comments of Accelerating the Socialisation of Social Welfare. [http://www.gov.cn/gongbao/content/2000/content\\_60033.htm](http://www.gov.cn/gongbao/content/2000/content_60033.htm) ed. Beijing.
- STATE COUNCIL OF CHINA 2001. The Tenth Five-Year Plan of National Economic and Social Development. Beijing.
- STATE COUNCIL OF CHINA 2006a. Accelerating the Construction of Care Provision System for Older People. *In*: GENERAL OFFICE OF THE STATE COUNCIL OF CHINA (ed.). Beijing.
- STATE COUNCIL OF CHINA 2006b. The Eleventh Five-Year Plan of National Economic and Social Development. Beijing.
- STATE COUNCIL OF CHINA 2011. The Twelfth Five-Year Plan of National Economic and Social Development. Beijing.
- STATE COUNCIL OF CHINA 2013. Suggestions on Accelerating the Development of Care for Older People. Beijing.
- STATE COUNCIL OF CHINA 2016a. Comments on the Comprehensive Opening-Up of the Care Service Market & Improving the Quality of Care Services. Beijing.
- STATE COUNCIL OF CHINA 2016b. The Thirteenth Five-Year Plan of National Economic and Social Development. Beijing.
- STATE INFORMATION CENTRE OF CHINA 2015. Research on Financial Investment in the Field of Care for Older People in China. Beijing.
- STIGLITZ, J. E. & ROSENGARD, J. K. 2015. *Economics of the Public Sector*, New York, W.W. Norton & Company, Inc.
- SU, Z., HU, Z. & PENG, X. 2017. The Impact of Changes in China's Family Patterns on Family

- Pension Functions. *International Journal of Health Planning and Management*, 32, 351-362.
- SUN, C. 2000. The Floating Population and Internal Migration in China. In: PENG, X. & GUO, Z. (eds.) *The Changing Population of China*. Oxford: Blackwell Publishers.
- SUN, J. 2017. Economic Income and Intergenerational Economic Support of the Urban and Rural Elderly in China. *Population Research*, 41, 34-45.
- SUN, Q. & MAXWELL, J. W. 2002. Deficits, Empty Individual Accounts, and Transition Costs: Restructuring Challenges Facing China's Pension System. *Journal of Insurance Issues*, 25, 103-126.
- TAI, P. 2013. On the Regulatory Effectiveness and Problem of Government Procurement Services: Based on the Empirical Research on the Current Situation of the Mainland's Public Service. *Journal of Liaoning University (Philosophy and Social Sciences Edition)*, 41, 5.
- TAMIYA, N., NOGUCHI, H., NISHI, A., REICH, M. R., IKEGAMI, N., HASHIMOTO, H., SHIBUYA, K., KAWACHI, I. & CAMPBELL, J. C. 2011. Population Ageing and Wellbeing: Lessons from Japan's Long-Term Care Insurance Policy. *Japan: Universal Health Care at 50 years 4*, 378, 1183-1192.
- TICHAPONDWA, S. M. 2013. *Preparing Your Dissertation at a Distance: A Research Guide*, Vancouver, Virtual University For Small States of the Commonwealth.
- UNGERSON, C. 1999. Personal Assistants and Disabled People: An Examination of a Hybrid Form of Work and Care. *Work Employment and Society*, 13, 583-600.
- UNGERSON, C. & YEANDLE, S. 2007. *Cash for Care in Developed Welfare States*, Basingstoke UK and New York, Palgrave Macmillan.
- UNITED NATIONS 2001. World Population Ageing:1950-2050. In: DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS POPULATION DIVISION (ed.). New York.
- WALSH, K. & SHUTES, I. 2013. Care Relationships, Quality of Care and Migrant Workers Caring for Older People. *Ageing & Society*, 33, 393-420.
- WANG, H., GUO, F. & CHENG, Z. 2015. Discrimination in Migrant Workers' Welfare Entitlements and Benefits in Urban Labour Market: Findings from a Four-City Study in China. *Population, Space and Place*, 21, 124-139.

- WANG, M. & LI, Z. 2012. Measurement of Inter-Generational Income Transfer of Chinese Residents. *Journal of Sun Yet-Sen University*, 235, 172-181.
- WANG, X., FAN, G. & YU, J. 2017. *Marketization Index of China's Provinces NERI Report 2016*, Beijing, Social Science Academic Press (China).
- WANG, X., PIESSE, J. & WEAVER, N. 2011. Mind the Gaps: A Political Economy of the Multiple Dimensions of China's Rural-Urban Divide. *Brooks World Poverty Institute Working Paper Series*. BWPI, The University of Manchester.
- WEBB, S. & WEBB, B. 1932. *Methods of Social Study*, London, Longmans, Green.
- WEDEMAN, A. H. 2003. *From Mao to Market: Rent Seeking, Local Protectionism and Marketization in China*, Cambridge, Cambridge University Press.
- WEI, Y. D. 2001. Decentralization, Marketization, and Globalization: The Triple Processes Underlying Regional Development in China. *Asian Geographer*, 20, 7-23.
- WHYTE, M. K. 2005. Continuity and Change in Urban Chinese Family Life. *China Journal*, 53, 9-33.
- WHYTE, M. K. 2010. *One Country, Two Societies: Rural-Urban Inequality in Contemporary China*, Cambridge, Massachusetts, Harvard University Press.
- WILDEMUTH, B. M. 2009. *Applications of Social Research Methods to Questions in Information and Library Science*, Westport, CT, Libraries Unlimited
- WILLIAMS, F. 2012. Converging Variations in Migrant Care Work in Europe. *Journal of European Social Policy*, 22, 363-367.
- WILLIAMS, F. & BRENNAN, D. 2012. Care, Markets and Migration in a Globalising World: Introduction to the Special Issue. *Journal of European Social Policy*, 22, 355-362.
- WISTOW, G., KNAPP, M., HARDY, B. & ALLEN, C. 1994. *Social care in a mixed economy*, Buckingham, Open University Press.
- WONG, D. F. K., LI, C. Y. & SONG, H. X. 2007. Rural Migrant Workers in Urban China: Living a Marginalised Life. *International Journal of Social Welfare*, 16, 32-40.
- WOOLHAM, J., DALY, G., SPARKS, T., RITTERS, K. & STEILS, N. 2017. Do Direct Payments Improve Outcomes for Older People Who Receive Social Care? Differences in Outcome Between People Aged 75+ Who Have a Managed Personal Budget or a Direct Payment. *Ageing and Society*, 37, 961-984.
- WU, F. 2001. China's Recent Urban Development in the Process of Land and Housing

- Marketisation and Economic Globalisation. *Habitat international*, 25, 17.
- WU, F. 2014. Commodification and Housing Market Cycles in Chinese Cities. *International Journal of Housing Policy*, 15, 6-26.
- WU, J., ZUIDEMA, C., GUGERELL, K. & DE ROO, G. 2017. Mind the Gap! Barriers and Implementation Deficiencies of Energy Policies at the Local Scale in Urban China. *Energy Policy*, 106, 201-211.
- WU, Z. 2004. From Over-Equalitarianism to Equity: The Evolution of China's Social Policy. *Sociological Studies (China)*, 75-89.
- XIAO, Y. & CHEN, T. 2013. The Optimization of Service Members in Private Pension Institutions. *Journal of Sichuan University of Science & Engineering (Social Sciences Edition)*, 28.
- XU, A. & XIA, Y. 2014. The Changes in Mainland Chinese Families During the Social Transition: A Critical Analysis. *Journal of Comparative Family Studies*, 45, 31-53.
- YAMASHITA, J., SOMA, N. & CHAN, R. K. H. 2013. Re-Examining Family-Centred Care Arrangements in East Asia. In: IZUHARA, M. (ed.) *Handbook on East Asian Social Policy*. Cheltenham, UK: Edward Elgar.
- YANG, L., LIU, C., FERRIER, J. A. & ZHANG, X. 2015. Organizational Barriers Associated with the Implementation of National Essential Medicines Policy: A Cross-Sectional Study of Township Hospitals in China. *Social Science & Medicine*, 145, 201-208.
- YANG, T. 2006. Evolution, Focus and Construction of China's Social Policy. *Study and Practice*, 79-88.
- YANG, T. 2011. Gongban Minying and Minban Gongzhu: Policy Analysis on Accelerating the Construction of Care Service Agencies for Older People. *The Journal of Humanities*, 124-135.
- YEANDLE, S., KRÖGER, T. & CASS, B. 2012. Voice and Choice for Users and Carers? Developments in Patterns of Care for Older People in Australia, England and Finland. *Journal of European Social Policy*, 22, 432-445.
- YEO, A., LEGARD, R., KEEGAN, J., WARD, K., NICHOLLS, C. M. & LEWIS, J. 2014. In-Depth Interviews. In: RITCHIE, J., LEWIS, J., NICHOLLS, C. M. & ORMSTON, R. (eds.) *Qualitative Research Practice: A Guide for Social Science Students & Researchers*. London: SAGE Publications Ltd.

- YIN, P. & HUANG, W. 2011. The Current Situation and Tendency of Rural Left-Behind Elderly Issues. *Jiangxi Social Sciences*, 195-199.
- YIP, W. & HSIAO, W. 2014. Harnessing the Privatisation of China's Fragmented Health-Care Delivery. *The Lancet*, 384, 805-818.
- ZHAN, H. J. 2013. Population Aging and Long-Term Care in China. *Generations-Journal of the American Society on Aging*, 37, 6.
- ZHAN, H. J., FENG, X. & LUO, B. 2008. Placing Elderly Parents in Institutions in Urban China - a Reinterpretation of Filial Piety. *Research on Aging*, 30, 543-571.
- ZHAN, H. J., LIU, G., GUAN, X. & BAI, H. 2006. Recent Developments in Institutional Elder Care in China. *Journal of Aging & Social Policy*, 18, 24.
- ZHANG, M. & RASIAH, R. 2014. Institutional Change and State-Owned Enterprises in China's Urban Housing Market. *Habitat International*, 41, 58-68.
- ZHANG, W. & WEI, M. 2015. Disability Level of the Chinese Elderly: Comparison from Multiple Data Sources. *Population Research*, 39, 14.
- ZHANG, X. 2006. Institutional Transformation and Marketisation: The Changing Patterns of Housing Investment in Urban China. *Habitat International*, 30, 327-341.
- ZHANG, Y. & GOZA, F. W. 2006. Who Will Care for the Elderly in China?: A Review of the Problems Caused by China's One-Child Policy and Their Potential Solutions. *Journal of Aging Studies*, 20, 151-164.
- ZHANG, Z. & TREIMAN, D. J. 2013. Social Origins, Hukou Conversion, and the Wellbeing of Urban Residents in Contemporary China. *Social Science Research*, 42, 71-89.
- ZHENG, B. 2016. *China Pension Report 2016*, Beijing, Economy and Management Publishing House.
- ZHOU, J. & WALKER, A. 2016. The Need for Community Care Among Older People in China. *Ageing and Society*, 36, 1312-1332.
- ZHOU, S., LIU, Y. & KWAN, M.-P. 2016. Spatial Mismatch in Post-Reform Urban China: A Case Study of a Relocated State-Owned Enterprise in Guangzhou. *Habitat International*, 58, 1-11.
- ZHU, C. J. & NYLAND, C. 2004. Marketization and Social Protection Reform: Emerging HRM Issues in China. *International Journal of Human Resource Management*, 15, 853-877.



## Appendix 1. The Administrative Divisions at Provincial Level in China

Provincial Level	22 provinces	
-34	4 municipalities	A higher-level city which is directly under the central government. i.e. Beijing, Shanghai, Tianjin, Chongqing
	5 autonomous regions	A minority entity which has a higher population of a minority ethnic group along with its own local government
	2 Special administrative regions	Hong Kong and Macau
	1 claimed province	Taiwan

Note: The People's Republic of China administers 33 provincial-level regions in 2017. "Cities" in Chinese (*shi*) include administrative governments at different levels: provincial-level (i.e. four municipalities), prefectural, sub-prefecture level, and county level cities. Shanghai, as one of the municipalities, is a provincial-level city under the central government.

Data source:

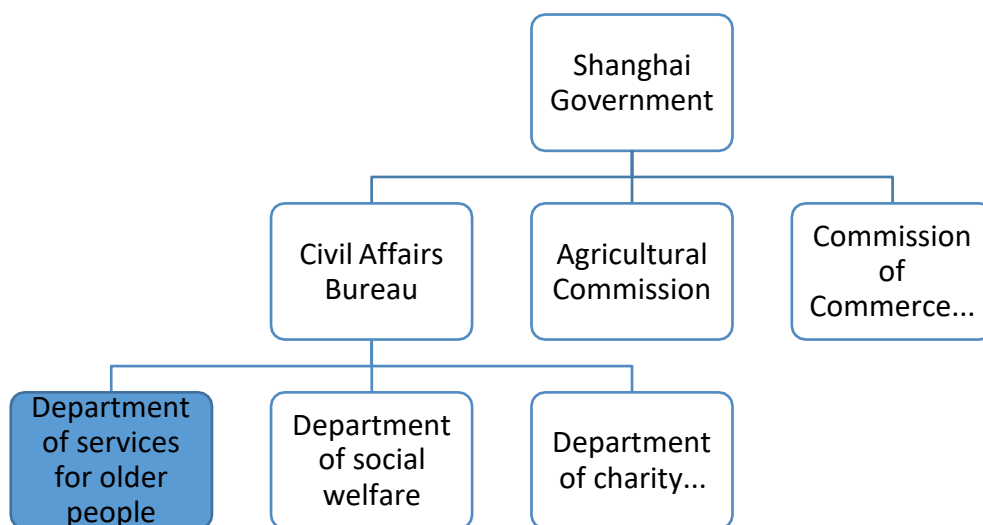
<http://www.china.org.cn/english/Political/28842.htm>;

[http://www.gov.cn/gjig/2005-08/28/content\\_27083.htm](http://www.gov.cn/gjig/2005-08/28/content_27083.htm);

[http://www.gov.cn/test/2005-06/15/content\\_18253.htm](http://www.gov.cn/test/2005-06/15/content_18253.htm).



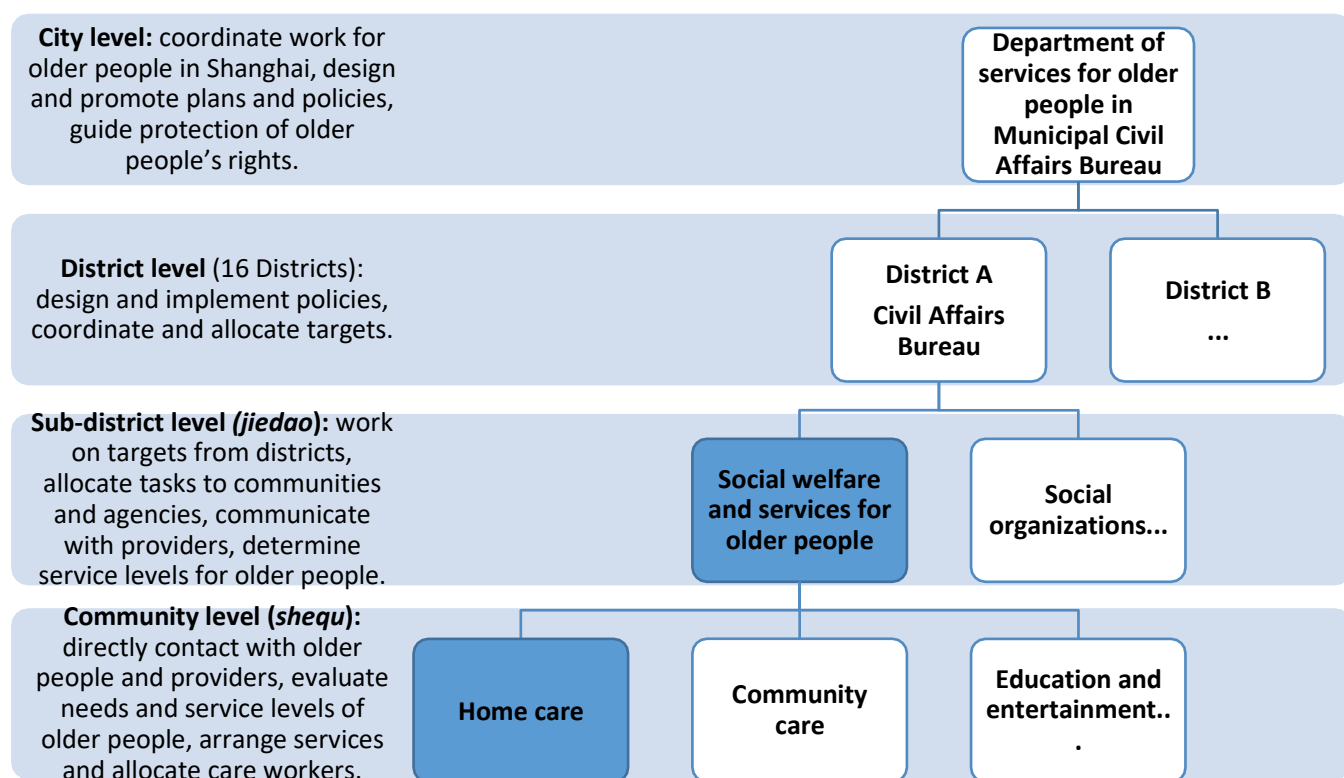
## Appendix 2. State Structure of Shanghai Government



Note: Shanghai government includes nine municipal bureaus: Civil Affairs Bureau, Agricultural Commission, Commission of Commerce, Auditing Bureau, Bureau of Quality and Technical Supervision, Bureau of Public Security, Bureau of Justice, and Civil Defence Office. Shanghai Municipal Bureau of Civil Affairs has 16 departments, including one for dealing with issues on older people.

Data source: Shanghai government: <http://www.shanghai.gov.cn/>; Shanghai Civil Affairs Bureau <http://www.shmzj.gov.cn/index.html>.

### Appendix 3. Hierarchy in the Department of Services for Older People in Shanghai



Note: There are 16 districts in Shanghai: Pudong, Huangpu, Jing'an, Xuhui, Changning, Putuo, Hongkou, Yangpu, Baoshan, Minghang, Jiading, Jinshan, Songjiang, Qingpu, Fengxian, and Chongming. In addition to the hierarchy within the line of services for older people shown in this diagram, the management of public officials also includes administrative control from governments at each level.

Data source: Shanghai Civil Affairs Bureau <http://www.shmzj.gov.cn/index.html>; Pudong District Civil Affairs Bureau <http://pd.shmzj.gov.cn/>; Yangpu District Civil Affairs Bureau <http://yp.shmzj.gov.cn/>.

## Appendix 4. Topic Guide for Interviews with Owners and Managers of Home Care Agencies

(translated from the original version in Chinese)

Target group: owners and managers in home care agencies

Focus on:

experiences in the field of care for older people; motivations for entering the care market; how is the care market developing in recent decades (processes); how are the relationships between the market and the state/family/community; what outcomes of changes in the home care market; expectations of the development/direction of home care in Shanghai / urban China; comments on shifting balance of the care system; understanding of the market and marketization.

---

### 1. Agency background

1.1 background information (e.g. when was this agency established? How about the coverage/size of this agency?)

What type/category do you categorize this agency? (e.g. Private, community, NGO, people-run, etc.)

1.2 What kind of services do you provide in this agency?

Who is funding the agency? (e.g. fully private funded, any financial support from the state or other organisations)

Who is paying for the services? If private purchasing involved, what is the proportion of older people and their families contributing to the income of your agency?

1.4 how is the profit model of this agency? (e.g. the balance point to get profits, income and expenditure)

1.5 employment of care workers

Could you describe the composition of care workers in this agency? (e.g. hometown, gender, age, education level, etc.)

employment relationship (length of contracts, stability, etc.)

What changes of recruitment have taken place in recent years?

---

---

## 2. Experiences in home care practice

Could you share your personal working experience in the field of home care/ care for older people?

e.g. How long, what position, how your daily work is, who do you work with?

---

## 3. Reasons/motivations for entering the care market /taking up employment in home care

---

### 4. Development processes of the care market

4.1 How are the needs of care services changing in recent years?

4.2 How is the supply of care services changing in recent years?

-which part has been covered by the market? What is the main responsibility of families?

4.3 What policies and schemes are applied regarding the delivery of home care services/ general care for older people?

4.4 How are these policies changing in recent years?

---

## 5. Impacts/ outcomes of changes in the home care market

5.1 What impacts of these changes in the home care market on the agency?

5.2 How about feedbacks from care recipients? What do the older people and their families think about the home care services? (e.g. demands proposed by older people and their families, comments on different services, etc.)

5.3 What challenges have you encountered in the delivery of home care services? (e.g. policy, employment, clients, etc.)

---

## 6. The role of home care in the care system

6.1 How do you define 'home care'?

6.2 What is the difference between 'home care' and 'community care'?

6.3 What is the position of home care in the care system in Shanghai/urban China?

6.4 What is the definition of '9073' of care for older people in Shanghai?

How is the current status of the mix of care from family members and care workers in home care?

How is the idea/percentage of '90' for home care developing in recent years?

6.5 Could you please comment on the shifting balance of the care system?

---

---

7. Relationship with other sectors (the state, the family) in care for older people

7.1 What is the role of families in the care provision for older people? Could give some detailed comments?

7.2 What is the role of the state in the care provision for older people? Could give some detailed comments?

7.3 What is the role of the market in the care provision for older people? Could give some detailed comments?

7.4 How about the relationship between these sectors? (e.g. market and state)

7.5 What changes have been taken place in the care market? What are your views on the changing role of the market in home care and care for older people?

---

8. Expectations of the development/direction of Home Care in Shanghai/China

e.g. comments and expectations for the development of care agencies and home care, policy needs, development plans, etc.

---

9. What is your understanding of the marketisation of care?

---

10. Do you want to add anything else about home care for older people?

---

## Appendix 5. Topic Guide for Interviews with Local Government Officials

(translated from the original version in Chinese)

Target Group: local government officials in the community and sub-district levels of Civil Affairs Bureau in Shanghai

Focus on: experiences on home care policy and practice; how is the care market developing in recent two decades; how are the relationships between the market and the state/family/community; recognized impacts/outcomes of changes in the home care market; views on the changing role of the market in home care and care for older people; expectations of the development of home care in Shanghai / urban China; comments on shifting balance of the care system; understanding of the market and marketization.

---

### 1. Background information on the institutional organisation

#### 1.1 Personal experiences in home care practice

Could you share your personal working experience in the field of home care/care for older people?

e.g. how long, what position, how your daily work is, who do you work with.

#### 1.2 What are the functional responsibilities of this office/department/your position? (e.g.: management, resources allocation, services)

How many people are there working in your office/department?

What is the structure of the workforce in terms of their levels of seniority?

#### 1.3 Do you have some guidelines for the allocation of funding/subsidy to agencies, care workers, and older people / their family?

What policy documents are the basis for the financial support?

How much is the budget for home care/ care for older people in your community/sub-district? How about the usage of the budget?

#### 1.4 management of care workers

What changes of recruitment and composition of care workers have taken place in recent 10 years?

---

---

Could you describe the characteristics of care labour under your management in your district/community? (e.g. hometown, gender, age, education level, etc.)

What is the employment relationship between the local government and these care workers? (temporary/long-term, length of contract, stability, etc.)

---

## 2. Developing processes of the care market

2.1 how are the needs changes of care for older people in recent years?

2.2 how are the supply changes of care for older people in recent years?

2.3 What policies and schemes are applied regarding the delivery of home care services/general care for older people in your district/community?

2.4 How are these policies changing in recent 10 years?

---

## 3. How are care policies proposed and implemented in your community/district/Shanghai?

3.1 How about the feedbacks processing or revision of these policies/schemes?

3.2 Who are the policymakers? Who can participate in the policy-making or revising process? Who evaluates the outcomes of policies?

3.3 What is your role in the policy-making and implementation process?

---

## 4. The role of home care in the care system

4.1 How do you define 'home care'?

4.2 What is the difference between 'home care' and 'community care'?

4.3 What is the position of home care in the care system in your district/community?

4.4 What is the position of home care in the care system in Shanghai/urban China?

4.5 What is the definition of '9073' of care for older people in Shanghai?

How do you think of the current status of the mix of care from family members and care workers in home care?

How is the idea/percentage of '90' for home care developing in recent years?

4.6 Could you please comment on the shifting balance of the care system: Is there a shifting balance? What kind of shift has this been (changing roles of the family and the state in dimensions of financing and service provision)? Do you think it has been beneficial to older people?

5. The relationship between the state, market, family, and community in care for older people

5.1 What are the roles of family, state, market, and community in the care for older people? Could give some detailed comments?

5.2 What do you think of the relationship between these sectors?

5.3 What changes have been taken place in the care market? What are your views on the changing role of the market in home care and care for older people?

---

6. Impacts/ outcomes of changes in the home care market

6.2 What impacts do you think are significant to the state/governments?

6.3 What impacts of these changes in the home care market on care recipients (older people and their families)?

6.4 What kind of regulations/evaluations/assessments are conducted by the government on the outcomes of policies/schemes regarding the care market?

6.5 What challenges have you encountered in the management and regulating of home care services?

6.6 In your opinion, what impacts of these changes in the home care market on the care system?

---

7. What expectations do you have on the development/direction of home Care in Shanghai/China?

---

8. What is your understanding of the marketisation of care?

---

9. Do you want to add anything else about home care for older people?



## Appendix 6. Informed Consent to Participation

(translated from the original version in Chinese)

I have read and understood the Participation Information Sheet of the research entitled: 'Home care for older people in urban China: impacts of the marketisation process' conducted by Wenjing Zhang.

☐

My participation is voluntary.

☐

I understand that I do not have to answer all questions and can terminate the interview during the interview without giving any reason.

☐

I am aware of a two-week 'cooling off' period after the interview, which means that I cannot withdraw my data after this period.

☐

I understand that the interviews are being voice recorded.

☐

I understand my responses will be translated into English by the researcher and used for anonymous quotes in this thesis and other publications arising from this research.

☐

I understand that all the data at the end of the project will be stored for 10 years on appropriate storage facility in order to comply with University of Bristol Data Storage Policy.

☐

Name of the participant:

Signature:

Date:

Name of the researcher: Wenjing Zhang

Signature:

Date:

If you have any further questions or concerns please contact the researcher by mobile

, or email [wz14877@bristol.ac.uk](mailto:wz14877@bristol.ac.uk).

## Appendix 7. The Participant Information Sheet

(translated from the original version in Chinese)

### **Home care for older people in urban China: analysis of the marketisation process**

#### **What is this research about?**

The researcher, Wenjing Zhang, is a PhD candidate based at the School of Policy Studies, University of Bristol, UK. This study aims to examine the impacts of marketisation process on home care policy and practice for older people in urban China. The research has ethical approval from the Research Ethics Committee of School for Policy Studies. The focus of this thesis is how the role of the market is developing; how the other sectors respond to these changes; and how the care regime is shaped and, in turn, shaping the practice in urban China. The primary objective is to explore existing and potential impacts of marketisation of home care on the care system and participants in the care market in urban China. I will investigate views and experiences of service providers and local regulators in the care market in Shanghai, and analyse policy priorities and emerging patterns of care for older people.

#### **What will happen if you participate?**

Your participation is voluntary. Before the interview, you will be asked to sign a consent form stating that you understand what the research is about, what your participation involves, and what happens to the data you provide. You are free to refuse to answer questions if uncomfortable or withdraw at any time during the interview. The interview will take around 1 hour. The researcher will record the interviews with your agreement (all identifying information will be anonymised. If you are happy to mention the background information (e.g. which district of Shanghai you are working in) in the thesis, it will be used on the basis of no identification of your personal information. You are not obliged to participate in this research if you do not feel comfortable in doing so. After the interview, you will have a two-week 'cooling off' period, which means the data cannot be withdrawn after this period to ensure the expected research progress.

#### **What will happen to the information you provide?**

The information you provide will be presented in my PhD thesis, which will be submitted to an exam board for examination purpose. The completed thesis will be available at the University of Bristol Library and the British Library. Your responses might also be used for anonymous quotes in other publications arising from this research. I will transcribe all the interview recordings by myself in Chinese and translate into English for quotations. Besides, in order to comply with University of Bristol Data Storage Policy, all the data at the end of the project will be stored for 10 years on appropriate storage facility.

### **Confidentiality**

All the information you provide will be kept strictly confidential. The interview data will only be used for research purpose. All your personal information will be made anonymous at the earliest convenience. The recordings and equipment will be stored securely. I will securely protect the interview data confidential from any other individuals or institutions. However, there are limits of confidentiality of this study. If you tell me something about illegal activities, I will discuss with my supervisors to make a decision about whether the confidentiality needs to be broken or not and would report these activities to related departments if necessary.

If you have any questions, please contact the researcher, Wenjing Zhang, [REDACTED] [wz14877@bristol.ac.uk](mailto:wz14877@bristol.ac.uk). If you have any further questions/complaints, please contact my supervisor Dr Misa Izuhara, [m.izuhara@bristol.ac.uk](mailto:m.izuhara@bristol.ac.uk).

## Appendix 8. Confidentiality Protocol

The interview data will only be used for research purpose. All personal information will be anonymised to avoid the identification of any participants. Pseudonyms will be used instead of real names. The recorder and data will be stored securely. All data will be made anonymous using a code only known by the researcher and the recordings will be wiped from the recorder at the earliest convenience. After applying anonymous measures, the researcher will securely protect the data confidential from any other individuals or institutions.

The limit of confidentiality in this research will be informed to participants. If something about illegal activities is mentioned (e.g. abuse in a care agency), I will discuss with my supervisors to make a decision about whether the confidentiality needs to be broken or not. Illegal activities will be reported to related departments if necessary. All participants will be made aware of this risk.

Interviews will be transcribed verbatim and checked for accuracy in Chinese while extracts for quotations will be translated into English with pseudonyms for names to use in the thesis and subsequent publications.

In order to comply with University of Bristol Data Storage Policy, all the data at the end of the project will be stored for 10 years on an appropriate storage facility.

## Appendix 9. School for Policy Studies: Research Ethics Committee Application Form

- This proforma must be completed for each piece of research carried out by members of the School for Policy Studies, both staff and doctoral postgraduate students.
- See the Ethics Procedures document for clarification of the process.
- All research **must** be ethically reviewed before any fieldwork is conducted, regardless of source of funding.
- See the School's policy and guidelines relating to research ethics and data protection, to which the project is required to conform.
- Please stick to the word limit provided. **Do not** attach your funding application or research proposal.

### Key project details:

1. Proposer's Name	Wenjing Zhang		
2. Project Title	Home care for older people in urban China: impacts of the marketisation process		
3. Project start date	September 2014	End date	September 2018

### Who needs to provide Research Ethics Committee approval for your project?

The SPS REC will only consider those research ethics applications which do not require submission elsewhere. As such, you should make sure that your proposed research does not fall within the jurisdiction of the NRES system:

<http://www.nres.nhs.uk/applications/approval-requirements/ethical-review-requirements/>

If you are not sure where you should apply please discuss it with either the chair of the committee or the Faculty Ethics Officer who is based in RED.

Currently NRES are not expected to consider applications in respect of activities that are not research: ie. clinical audit, service evaluation and public health surveillance. In addition REC review is not normally required for research involving NHS or social care staff recruited as research participants by virtue of their professional role. Social care research projects which are funded by the Department of Health, must always be reviewed by a REC within the Research Ethics Service for England. Similarly research which accesses unanonymised patient records must be reviewed by a REC and NIGB.

### Do you need additional insurance to carry out your research?

Yes. I will travel overseas (China) for field work. I have already submitted the application for the university travel insurance for the overseas research.

Whilst staff and doctoral students will normally be covered by the University's indemnity insurance there are some situations where it will need to be checked with the insurer. If you are conducting research with: Pregnant research subjects or children under 5 you should email: [insurance-enquiries@bristol.ac.uk](mailto:insurance-enquiries@bristol.ac.uk)

In addition, if you are working or travelling overseas you should take advantage of the university travel insurance.

### Do you need a Criminal Records Bureau Check?

No.

Please see the current guidance to determine whether you are required to obtain a CRB check:

<http://webarchive.nationalarchives.gov.uk/+/http://www.homeoffice.gov.uk/publications/agencies-public-bodies/crb/about-the-crb/eligible-positions-guide?view=Binary>

If you think you need a CRB check, employed staff should contact Personnel, all students should check the University countersignatories page for information: <http://www.bristol.ac.uk/secretary/legal/disclosure/countersigs.html>

4. If your research project requires REC approval elsewhere please tell us which committee, this includes where co-researchers are applying for approval at another institution.  
Please provide us with a copy of your approval letter for our records when it is available.

Not applicable

5. Have all subcontractors you are using for this project (including transcribers, interpreters, and co-researchers not formally employed at Bristol University) agreed to be bound by the School’s requirements for ethical research practice?

Yes		
No/Not yet		
Not applicable	√	Note: You must ensure that written agreement is secured before they start to work

6. If you are a PhD/doctoral student please tell us the name of your research supervisor

Misa Izuhara, Liz Lloyd

## ETHICAL RESEARCH PROFORMA

The following set of questions is intended to provide the School Research Ethics Committee with enough information to determine the risks and benefits associated with your research. You should use these questions to assist in identifying the ethical considerations which are important to your research. You should identify any relevant risks and how you intend to deal with them. Whilst the REC does not comment on the methodological design of your study, it will consider whether the design of your study is likely to produce the benefits you anticipate. **Please avoid copying and pasting large parts of research bids or proposals which do not directly answer the questions.** Please also avoid using *unexplained* acronyms, abbreviations or jargon.

1. **EXPECTED DURATION OF RESEARCH ACTIVITY:** Please tell us how long each researcher will be working on fieldwork/research activity. For example, conducting interviews between Feb 12 – July 2012. Also tell us how long participant involvement will be. For example: Interviewing 25 professional participants X2 for a maximum of 1 hour per interview.

This research project is solely responsible by the PhD candidate for her thesis. 30 interviews are planned to conduct between Feb – May 2016. Each interview will take on average one hour. Participants will be free to terminate the interview if uncomfortable during the interview. Participants will also be offered the opportunity to make comments on their interview transcripts if interested (within one month after the interview). The following data analysis and writing up will be finished by September 2017.

2. **IDENTITY & EXPERIENCE OF (CO) RESEARCHERS:** Please give a list of names, positions, qualifications, previous research experience, and functions in the proposed research of all those who will be in contact with participants.

Researcher: Wenjing Zhang, PhD candidate in Social Policy.

I have a BSc in Social Work in China and MSc in Social Policy in the UK. The research training in the past few years has enabled me to be familiar with social policy research. During the undergraduate study, I interned as a social worker in a nursing house in Shanghai for fifty working days, conducting case work and group work with care workers and older people. For my master thesis on how the rural-urban migration is shaping the provision of care for older people in China, I collected administrative data from 3 nursing houses in Shanghai and interviewed 3 nursing house managers and 8 migrant care workers. For the data collection of my PhD thesis, I went to Shanghai for a field contact in August 2015. I have discussed the research proposal and potential data collection with my personal contacts who have working connections in the field of home care for older people in Shanghai.

3. **STUDY AIMS/OBJECTIVES [maximum of 200 words]:** Please provide the aims and objectives of your research.

This study aims to examine the impacts of marketisation process on home care policy and practice for older people in urban China. The focus of this thesis is how the role of the market is developing; how the other sectors respond to these changes; and how the care regime is shaped and, in turn, shaping the practice in urban China. The primary objective is to explore existing and potential impacts of marketisation of home care on the care system and participants in the care market in urban China.

This leads to the following objectives:

- Examine the rationale behind the marketisation of care
- Understand the marketisation trend of home care
- Explore processes of marketisation of home care

Service providers and local regulators are active stakeholders in the care market in urban China, but their ideas and experiences are absent in existing research. I will investigate their views and experiences and analyse policy priorities and emerging patterns of care for older people in urban China. This thesis will produce valuable findings of their role in the policy process.

4. **RESEARCH METHODS AND SAMPLING STRATEGY [maximum of 300 words]:** Please tell us what you propose to do in your research and how individual participants, or groups of participants, will be identified and sampled. Please also tell us what is expected of research participants who consent to take part (Please note that recruitment procedures are covered in question 8)

This is a qualitative research. Semi-structured interviewing is the main research method of data collection for this thesis, while relevant policy documents and secondary data will be reviewed to support the analysis of policy priorities and directions of elder care in urban China. I will employ purposive sampling to recruit 20 service providers in home care agencies and 10 local government officials as local regulators. The sampling criteria is:

- Within the category of service providers, 10 managers in private agencies (no direct financing or management from the government) and 10 managers in community agencies (partly or fully controlled by the government) will be recruited.

- The local regulators are public officials who have direct working connections with care agencies and service users in the community and sub-district levels of Civil Affairs Bureau in Shanghai.

If I cannot recruit enough interviewees through the introduction of my personal contacts, the snowballing sampling will be applied to expand the variety of means to approach participants. In this case, I will ask participants to introduce potential interviewees in my target sampling criteria (service providers or local regulators).

I plan to conduct pilot interviews to check the flow and clarity of questions before the main interviews. The topic guides will be reformulated in a cyclical process with feedback from the interviewees.

5. **POTENTIAL BENEFITS AND TO WHOM: [maximum 100 words]** Tell us briefly what the main benefits of the research are and to whom.

The increasing marketisation of home care in urban China are still neglected research areas. My thesis will explore the model of marketisation of home care in urban China to fill the research gap. This research explores experiences and viewpoints of service providers and local regulators. This research will not directly benefit the participants. Instead, it will improve the care practice with long-term benefits, by indicating the impacts of marketisation on home care in Shanghai, leading further development of care practice in urban China, as well as contributing to the literature on the marketisation of care in the global context.

6. **POTENTIAL RISKS/HARM TO PARTICIPANTS [maximum of 100 words]:** What potential risks are there to the participants and how will you address them? List any potential physical or psychological dangers that can be anticipated? You may find it useful to conduct a more formal risk assessment prior to conducting your fieldwork. The University has an example of risk assessment form: <http://www.bristol.ac.uk/safety/policies/>

RISK	HOW IT WILL BE ADDRESSED
<i>Example 1: Participants may be upset during the interview</i>  <i>Example 2: A participants may tell me something about illegal activity</i>	<i>Example 1: If a participant gets upset I will stop the interview at that time. I will give participants information about support services at the end of the interview.</i> <i>Example 2: The information sheet and consent form will warn of the limits of confidentiality and I will have a confidentiality protocol (submitted to the committee).</i>
Participants may worry that their responses would be known to other stakeholders	I will inform the participants that their responses will be strictly confidential, protected from any other stakeholders (policy makers, public officials, or other agencies) in their business. The confidentiality will be stated clearly in the Participation Information Sheet and orally explained again at the beginning of the interviews.
Participants may feel obliged to take part in the research	My personal contacts have equal working connections with potential participants, which will not give unexpected pressure for them to participate. The recruitment letter and information sheet will state clearly that it is their voluntary decision on whether or not to participate the research.
Participants may tell me something about illegal activity	The participants will be informed about limits of confidentiality. Even though this research will not include sensitive or personal questions, something about illegal activity might be been mentioned (e.g. abuse in a care agency). In these cases, I will discuss with my supervisors to make a decision about whether the confidentiality needs to be broken or not. I will report illegal activities to related departments if necessary.

\*Add more boxes if needed.

7. **RESEARCHER SAFETY [maximum of 200 words]:** What risks could the researchers be exposed to during this research project? If you are conducting research in individual's homes or potentially dangerous places then a researcher safety protocol is mandatory. Examples of safety protocols are available in the guidance.

All interviews will be conducted during office hours in workplace, such as interviewees' offices and meeting rooms. I will inform a second person (family or friend) about the date and location of each interview. All participants will be aware of this arrangement. I will commute to the interview places by public transport (bus or underground). A mobile phone will be kept in my pocket to call for help in any emergency. I have registered a mobile number in Shanghai, which will be used exclusively for this research to contact with participants. During my fieldwork period, I will have a monthly check with my supervisors to report the progress of the interviews and my health and safety situation.



8. **RECRUITMENT PROCEDURES [maximum of 400 words]:** How are you going to access participants? Are there any gatekeepers involved? Is there any sense in which respondents might be “obliged” to participate (for example because their manager will know, or because they are a service user and their service will know), if so how will this be dealt with.

Four personal contacts will be asked to introduce potential interviewees, including two lecturers in the social work department in a university, one manager in a care institution, and one staff member in a consulting firm for the elder care industry. I will ask my contacts to distribute a recruitment letter and a participation information sheet (see Appendix 2 and 3) about the research aim, objectives, procedure, confidentiality, and my contact details to people who might be interested. There is no ‘obliged’ pressure for those potential participants to take part in the research since my personal contacts have equal working connections with them. After received initial interests and contact information of potential participants, I will contact them via email, phone calls, or personal visits before interviews. If the purposive sampling through my personal contacts cannot meet the expected sample size, the snowballing sampling will be used to enhance the variety of means to approach more participants. A small box of chocolates will be provided as a gift for their assistance.

9. **INFORMED CONSENT [maximum of 200 words]:** How will this be obtained? Whilst in many cases written consent is preferable, where this is not possible or appropriate this should be **clearly justified**. An age and ability appropriate participant information sheet (PIS) setting out factors relevant to the interests of participants in the study must be handed to them in advance of seeking consent (see materials table for list of what should be included). If you are proposing to adopt an approach in which informed consent is not sought you must explain in detail why this is not considered to be appropriate. If you are planning to use photographic or video images in your method then additional/separate consent should be sought from participants which adheres to the relevant data protection legislation. Current guidance is that consent forms should ask participants to initial rather than tick the consent boxes on the consent form.

Please tick the box to confirm that you will keep evidence of the consent forms (either actual forms or digitally scanned forms) in accordance with the data protection legislation, securely for ten years.



All participants will be asked for consent to participation. The participant information sheet (Appendix 3) will provide an introduction to the study and assurances about confidentiality to the interviewees. Each interviewee will be asked for written informed consent and permission for digital recording before the interview. They must fully understand the research process and attend the interviews voluntarily. Participants will have a two-week ‘cooling off’ period, which means the data cannot be withdrawn after the cooling off period to ensure the expected research progress. I will state clearly in the consent form and explain orally again at the beginning of the interview about the anonymity and confidentiality of this study.

10. **DATA PROTECTION:** All applicants should regularly take the data protection on-line tutorial provided by the University in order to ensure they are aware of the requirements of current data protection legislation. University policy is that “personal data can be sent abroad if the data subject gives unambiguous written consent. Staff should seek permission from the University Secretary prior to sending personal data outside of the EEA”. Any breach of the University data protection responsibilities could lead to disciplinary action.

Have you taken the mandatory University data protection on-line tutorial in the last 12 months Yes ☒

No ☐

[https://www.bris.ac.uk/is/media/training/uobonly/datasecurity/page\\_01.htm](https://www.bris.ac.uk/is/media/training/uobonly/datasecurity/page_01.htm)

Do you plan to send any information/data, which could be used to identify a living person, to anybody who works in a country that is not part of the European Union?

Yes ☐

No ☒

(see [http://www.ico.gov.uk/for\\_organisations/data\\_protection/the\\_guide/principle\\_8.aspx](http://www.ico.gov.uk/for_organisations/data_protection/the_guide/principle_8.aspx))

If YES please list the country or countries:

# 11. CONFIDENTIALITY AND ANONYMITY:

	YES	NO
All my data will be stored on a password protected server	<input checked="" type="checkbox"/>	<input type="checkbox"/>
I will only transfer unanonymised data if it is encrypted (For advice on encryption see: <a href="http://www.bristol.ac.uk/infosec/uobdata/encrypt/device/">http://www.bristol.ac.uk/infosec/uobdata/encrypt/device/</a> )	<input checked="" type="checkbox"/>	<input type="checkbox"/>
If there is a potential for participants to disclose illegal activity or harm to others you will need to provide a confidentiality protocol.	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Please confirm that you warned participants on the information and consent forms that there are limits to confidentiality and that at the end of the project data will be stored for 10 years on appropriate storage facility. <https://www.acrc.bris.ac.uk/acrc/storage.htm>

Confirmed



**12. SHARING DATA AND DISSEMINATION OF FINDINGS [maximum 200 words]:** Are you planning to send copies of data to participants for them to check/comment on? If so, in what format and under what conditions? What is the anticipated use of the data, forms of publication and dissemination of findings etc? If you plan to archive your interview transcripts then ensure that consent is obtained.

The interviews will be recorded with a digital voice recorder when permitted. The recordings will be downloaded to a password protected computer. I would not invite participants for comments. However, if they ask to check or comment on the data, I will provide the transcribed data within one month after their interview. All identifying features will be removed from the transcription to keep anonymization. Interviews will be transcribed verbatim and checked for accuracy in Chinese while extracts for quotations will be translated into English with pseudonyms for names. The interview transcripts are going to be used anonymously for my thesis and further publications arising from this research. Participants will be informed that all the data will be stored for 10 years on appropriate storage facility complying with University of Bristol Data Storage Policy.

**13. ADDITIONAL INFORMATION:** Please identify which of the following documents, and how many, you will be submitting within your application: Guidance is given at the end of this document (appendix 1) on what each of these additional materials might contain.

ADDITIONAL MATERIAL	NUMBER OF DOCUMENTS:
Participants information sheet (s)	1
Consent form (s)	1
Confidentiality protocol	1
Researcher safety protocol	0
Recruitment letters/posters/leaflets	1
Photo method information sheet	0
Photo method consent form	0
Risk assessment form	0
Support information for participant	0
3 <sup>rd</sup> party confidentiality agreement	0
Other information	0

Please DO NOT send your research proposal or research bid as the committee will not look at this.

## SUBMITTING & REVIEWING YOUR PROPOSAL:

To submit your application you should create a **single PDF document** which contains your application form and all additional material and submit this information to the SPS REC admin. Zaheda Tariq, [Zaheda.Anwar@bristol.ac.uk](mailto:Zaheda.Anwar@bristol.ac.uk)  
If you are having problems with this then please contact Zaheda to discuss.

Your form will then be circulated to the SPS Research Ethics Committee who will review your proposal on the basis of the information provided in this single PDF document. The likely response time is outlined in the 'Ethics Procedures' document. For staff applications we try to turn these around in 2-3 weeks. Doctoral student applications should be submitted by the relevant meeting deadline and will be turned around in 4 weeks.

Should the committee have any questions or queries after reviewing your application, the chair will contact you directly. If the committee makes any recommendations you should confirm, in writing, that you will adhere to these recommendations before receiving approval for your project.

Should your research change following approval it is **your responsibility** to inform the committee in writing and seek clarification about whether the changes in circumstance require further ethical consideration.

**Failure to obtain Ethical Approval for research is considered research misconduct by the University and is dealt with under their current misconduct rules.**

Chair: [e.williamson@bristol.ac.uk](mailto:e.williamson@bristol.ac.uk)

Date form updated by committee: March 2012.